

Mental Health and Mental Disorder

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Mental Health and Mental Disorder

A Sociological Approach

Edited by

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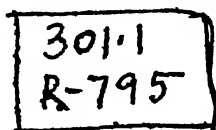
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Preface

IN OUR individualistic culture, with its tendency to search for causes of all sorts of human behavior in biological factors, a fruitful relationship between psychiatry and sociology was late in developing. There were a few scattered efforts of psychiatrists to think of social variables and of sociologists to examine psychiatric problems as early as the second decade of this century, but systematic cross-fertilization leading to concrete research did not really get under way until the 1930's. Since then probably most psychiatrists have been willing to think in terms of social factors in the etiology and therapy of mental disorders, and a small but increasing number of sociologists have undertaken relevant researches. In the last decade or so, a field of "social psychiatry" may properly be said to have been delineated. An examination of the literature in the field suggests that it is still very weak and that its outlines are not clear-cut, and that it has sometimes made exaggerated claims which it cannot fulfill.

Nevertheless the field has developed to the point where systematic review may now be deemed advisable. There has been some summarization in books on personal and social disorganization, and Professor S. Kirson Weinberg has written *Society and Personality Disorders*. We now offer this collection of essays, case studies, research reports, and systematic analyses of the literature. In thus providing this concentration of material to psychiatrists and sociologists, we hope to encourage the fruitful research collaboration which has already begun in several places and to aid in the delineation and systematization of an emerging subdiscipline. We have another major purpose: to make available to beginning students many of the scattered materials of this field so that they may acquire their initial orientation efficiently. Further, nearly a fourth of the selections in this book are being published for the first time, and thus the book has the character of a primary source as well as of an overview.

While most of the authors have had their primary training as sociologists, several are psychiatrists, psychologists, and anthro-

pologists. In this truly inter-disciplinary field, the formal educational background of an investigator is of less importance than the scope and quality of his contribution. To further this point of view we shall not make invidious distinctions by labeling our authors as to discipline or by designating them as having the degree of Ph.D., M.D., or M.A.

Each selection in the volume is reprinted as a unit (although a few selections have been cut from their original size), and I have not attempted to connect them except by assembling them under section heads. Readers and teachers may select their own order of reading the separate pieces and to consider them in contexts other than those in which they are presented here. For the reader or teacher who wishes to follow our ordering of the selections, he will find them beginning with a statement of problems in social psychiatry and a history of thought and early research on these problems, moving through a description of the social characteristics of the mentally disordered to a consideration of the societal settings in which the mentally disordered are found. While many of the selections throughout the book take up tangentially the social factors in the etiology of mental disorder, this is the primary concern of Section IV. An analysis of the social formation of the human personality is then presented to provide a broader social psychological context for our problem. Section VI takes up a number of other social problems that are akin to that of mental disorder. The book closes with some considerations necessary for the alleviation of mental disorder.

There are obvious gaps in this volume: certainly not all possible topics have been covered and not all worthy articles have been included. Space, planning, and clearance consideration made rigorous selection necessary. I have had the benefit of advice, in this selective process, from the members of the committee whose names are listed on the title page, but the final responsibility rested with me. I wish to take this opportunity to thank the committee and the authors for their fine co-operation. I especially want to thank Alfred M. Lee, President of the Society for the Study of Social Problems, for handling matters concerning the publication of this book. Assisting me with various editorial chores were my students, Richard Emerson, David Shaw, and Hans Zetterberg, and their work is gratefully acknowledged. Appreciation is also expressed to the University of Minnesota and to the Rockefeller Foundation for making some of my time and the assistants' time available.—A.M.R.

Mental Health and Mental Disorder

SECTION I

Problems of Social Psychiatry and Theoretical Overview

ONE

Mental Health in Modern Society*

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FIRST of all, it is necessary to understand and to define the relation between mental health and society. Mental health denotes the emotional stability and intellectual efficiency of the members of society. The conception is of an aggregate of individuals, each one of which is psychologically effective in his relations with his fellows.

Society, on the other hand, is a great organized structure of the social relations of its members. When society is well organized, it provides through its institutions and groups the necessary roles to utilize the energies and to realize the wishes of its members.

The thesis of this paper is that an important factor, perhaps the most important single factor in mental disorders and disturbances, is the failure of society to provide adequately for the social roles essential for the mental health of its members. By its failure to devise and to maintain satisfying roles and relationships society creates and is therefore responsible for the misfits, the unadjusted and maladjusted persons who are or become either criminals or mentally ill or both.

A program of mental health obviously has two sides. One is therapeutic and remedial, seeking to restore the mentally ill to normal health or at least to improve their condition; the other is preventive and positive, attempting to deal with the factors deter-

* Prepared especially for this volume.

mining mental conflicts and breakdowns. This paper will deal almost entirely with the role of social factors in preventive mental health. But many of the points to be made will apply as well to the therapeutic aspects of mental hygiene.

The discussion of the social factors affecting mental health will be presented under the following heads: (1) the role of the family and other intimate groups in mental health; (2) the place of the neighborhood and the community in a mental-health program; and (3) the nature of modern society in relation to the problems of mental health.

THE ROLE OF THE FAMILY AND OTHER INTIMATE GROUPS

Fifty years ago the causes of mental disturbances and disorders were thought to be entirely hereditary. Now, as a result of research by biologists, psychologists, psychiatrists, and sociologists three main factors, constitutional, individual, and environmental, are believed to cause mental breakdown. These factors, however, do not operate independently or in a vacuum. They get expression in combination with each other in difficulties of adjustment in personal and social relations. A preventive program for mental health, therefore, does not deal with the individual as a separate entity. Instead, it centers its effort upon the person as a member of groups, of the community, and of society.

Of all the groups of which the person is a member, the most important for his destiny is the family. Research by cultural anthropologists, psychiatrists, psychologists, and sociologists all show the paramount importance of the family in shaping personality. Students of personality perceive in disturbances and maladjustments of the relations between father and mother, parents and children, and between siblings, the genesis of neuroses and of psychoses.

Psychotherapy, as a program of treatment, is largely concerned with enabling the patient to perceive the dynamic relation of childhood relationships to parents and siblings to his present behavior problems. This procedure in the past has been time-consuming and expensive. Even short psychotherapy involves many hours of counseling.

Child-guidance counselors also find that behavior problems of children derive from maladjustments in family relations. Success in dealing with the child often involves the feasibility of treating

difficulties in their relations to their parents and in the relations of the parents to each other.

The family is therefore the crucial group in the preventive way toward mental health. The happy family, united by ties of affection and companionship, is our greatest resource for mental health.

The American family, however, is far from reaching this mental-health ideal. The family is increasingly unstable. For two generations, divorce has steadily increased with an average increment in rate each year of three per cent. It has now reached an annual ratio of one divorce to every four marriages. An undetermined but large proportion of other families suffer from unhappiness arising from conditions inimical to the mental health of their members. Some of these are tensions between husbands and wives and between parents and children, parental overpossessiveness and over-indulgence, sibling rivalry, and feelings of insecurity and rejection. The family, without question, is central in a preventive program for mental health.

What, however, is the role of the family in modern society? The answer to this question is a precondition to its solution. The crux of the problem is that the family is in transition from the institutional to the companionship form.

In the colonial period the family was held together by the forces of law, mores, and public opinion. The husband and father was head of the family, with the power of decision-making. The family was generally an economic unit, both of production and of consumption. Marriages of children were largely arranged by parents. The concepts of status, respect, and duty regulated family relationships. In short, these were the chief characteristics of the institutional family.

At present an increasing number of families are organized on the principle of companionship of husband and wife and of parents and children. Marriages are in the control of young people. Decision-making takes place by consensus of husband and wife, in which the children progressively participate. The family in the great majority of cases is no longer a unit of production and the occupations of its members are outside the home. The chief characteristics of the companionship family are to be found in the giving and receiving of affection and in the happiness to be derived from satisfying interpersonal relations.

The problems of the modern family inhere very largely in this transition from the authoritarian institutional family to the demo-

cratic companionship family. Where husband and wife enter marriage with different expectations of their mutual roles conflicts are certain to arise. For example, the husband may insist on the rigid disciplining of the children while the wife desires to follow the developmental program advocated in child-study groups.

Evidently, one way to mental health is the launching of a nationwide program of preparation for marriage and family living. This program should center in the public schools, since they reach practically all children and youth. It should ramify out through all the character-building agencies such as the church, the social center, the Y.M.C.A., the Y.W.C.A., and other boys' and girls' clubs and groups.

Closely related to this program of mental-health education is provision for marriage and family counseling. Young people must have counseling before marriage if they are to be prepared to meet problems of marital adjustment, particularly those likely to confront each given couple. Counseling after marriage is also necessary if difficulties are to be treated in their early acute forms before they have become chronic tensions difficult to resolve.

Of first importance for happy family life is greater care in the selection of a mate. The romantic myth that love is enough for marital happiness is now exploded. Love arising from companionship is being recognized as the sound basis for success in marriage. Findings from psychological and sociological research are now available as guides for happy unions. This new knowledge underlines the importance of utilizing the stages of dating, courtship, and engagement to determine if the members of the couple are compatible and companionable. Compatibility consists in congeniality of temperament and in mutuality in satisfying each other's personality needs. Companionability involves vital common or shared interests, similar or complementary cultural backgrounds, and agreement on ideals and objectives.

Other groups beside the family are significant for the mental health of the person. Each person tends to have one particular group which is of first importance to him. To the child it is likely to be his play group. To the man it is often his occupational or vocational group. To the woman it is her social set or her bridge club. But any group may have this special significance if it is the most vital one in satisfying the social needs of the person.

How important for the mental health of the person such a special interest group may be is readily seen in two examples. Alcoholics

Anonymous is recognized by experts and laymen alike as providing its members the social stimulation and the group support necessary for maintaining mental health. Recovery Incorporated, an association of recovered mental patients, is an organization which has been helpful to patients discharged as cured or improved in maintaining their mental health against the stigma upon mental illness still prevalent in the public mind.

A sound principle, then, is that membership in a vital interest group is essential to the mental health of the person. Isolation of the person from social groups is symptomatic of social ill health. One important way to good mental health is the placing of isolates in the type of social group best suited to their personality needs and interests.

THE NEIGHBORHOOD AND THE LOCAL COMMUNITY

While the family and other vital social groups are of great significance for positive mental health they are not the basic units for formulating and carrying out its program. The basic units are the neighborhood or the local community and its institutions, such as the church, the school, and industry.

The neighborhood, which is a cluster of families living in proximity, is the smallest geographical unit for concerted action. It typically acts through the church or the school or through some voluntary association such as a neighborhood improvement society. The community is an aggregate of neighborhoods served by a common trading center. The present tendency is for the local community to supersede the neighborhood as the basic unit in action for community welfare.

There is no doubt that problems of mental health, like all social problems, are concentrated in certain communities and thin out in other communities. In fact, urban studies have shown that a number of our problems tend to decrease as one proceeds from the slum areas around the central business districts of the city out to the residential suburbs at its periphery. Problems of which this is true for the city of Chicago include the following: patients in public and private mental hospitals, deaths, morbidity, bad housing, poverty, adult crime, and juvenile delinquency. Significantly, communities with high rates of mental disorders also have high rates of these other problems.

The same areas which have high rates of mental disorders and social problems are those with the lowest degree of social organization. Those areas with low rates of mental and social problems have the highest degree of social organization. For example, the proportion of people participating in voluntary associations is highest in neighborhoods with a low rate of admissions to mental hospitals and lowest with a high rate of admissions.

Studies of membership in organizations by social class and economic status indicate the same relationship. The following data should be interpreted in relation to the findings of Robert E. Clark that the rates for the different mental disorders except manic-depression vary inversely according to the socio-economic status of patients admitted to mental hospitals: ¹

Komarovsky shows that for urban dwellers participation in voluntary associations rises regularly from the occupation of lowest status and income to those of the highest. For example, for men, the percentage of participation is as follows: (1) unskilled labor, 32; (2) skilled labor, 44; (3) white collar with income under \$3000, 47; (4) business (\$3000 to \$10,000) 67; (5) professional under \$3000, 68; (6) professional (\$3000 to \$5000), 84; and (7) professional (\$5000 to \$10,000), 98.² Several studies for social class show a similar rise in participation in voluntary associations from the lowest to the highest social class.³ In a random five per cent sample of family dwelling units in Bennington, Vermont, J. C. Scott, Jr., found the average participation in voluntary associations to rise from low to higher class identification both for men and for women: lower class, .67 for men, .38 for women; lower-middle, 1.62 and .98; middle-middle, 2.15 and 1.16; upper-middle, 2.89 and 3.11; and upper, 5.20 and 3.00.⁴

The conclusion seems inescapable that a high degree of social organization is associated with good mental health and a small

¹ Robert E. Clark, "Psychoses, Income, and Occupational Prestige," *American Journal of Sociology*, 54 (1949), p. 440.

² Mirra Komarovsky, "The Voluntary Associations of Urban Dwellers," *American Sociological Review*, 9 (1946), p. 687.

³ Herbert Goldhamer, "Some Factors Affecting Participation in Voluntary Associations." Unpublished Ph. D. thesis, University of Chicago Libraries (1942), p. 69.

W. Lloyd Warner and Paul S. Lunt, *The Social Life of a Modern Community*. New Haven, Yale University Press (1941), p. 329.

⁴ J. C. Scott, Jr., "Membership Participation in Voluntary Associations." Unpublished Ph. D. thesis, University of Chicago Libraries (1948).

extent of social problems. Conversely, a low degree of social organization is correlated with a high rate of mental disorders and of social problems.

Local community organization in areas where it is absent or feeble is therefore an essential way to mental health. But is it feasible to organize citizens in a disorganized area? It is difficult but possible if residents in a neighborhood can unite for a common objective which they recognize as vital to them.

An experiment in community organization with far-reaching significance for mental health has been carried out by the Chicago Area Project. This project has now been in operation for twenty-two years. Its central purpose has been the reduction and control of juvenile delinquency in neighborhoods and local communities of Chicago where the rates of juvenile delinquency were much higher than the average for the city. The basic assumption of the project was that juvenile delinquency was a result, in a large measure, of lack of neighborhood organization. The way relied on was to present the facts and the plan of action to leading local residents of three neighborhoods with high delinquency rates.

When this project was initiated in 1932 at the depth of the depression certain outstanding civic leaders and social workers tried to discourage Clifford R. Shaw, its originator and proponent. They told him that these delinquency areas had no leaders left because they were constantly drained of those who, as they became successful, moved to more desirable areas to live and rear their children. Mr. Shaw was not disturbed by this objection. As a sociologist he knew that wherever there are people there are leaders.

A second objection gave him more concern. It ran as follows: "Poor economic conditions are the chief, or, at least, an important factor in juvenile delinquency. This is the depth of the depression. In undertaking this project now, you are certain to fail." Mr. Shaw, however, stuck to his guns. He asserted that he was convinced that the main cause of juvenile delinquency did not lie in economic conditions but in the social disorganization of these areas.

The third objection was the most difficult to answer. It was that if these were areas of social *disorganization* it would be most difficult to introduce social *organization*. In short, all the forces which had made and kept them disorganized would handicap and

prevent any attempt at a plan of organization to deal with, reduce, and prevent juvenile delinquency.

Mr. Shaw recognized the full impact of this objection. He was not deterred by the obstacles. If social disorganization was the chief cause of juvenile delinquency, then social organization was the solution. If the citizens of these high delinquency areas would not unite in a community program for the welfare of their children, it was high time to learn the facts and to proceed accordingly.

In all three neighborhoods the local citizens formed community committees and took full responsibility for the project. They introduced recreational programs or supplemented existing ones. They made the objective of their program the welfare of all the children with attention to the delinquent and especially the pre-delinquent child as incidental but at the same time essential.

In the conduct of the project all the difficulties that had been suggested and others unanticipated arose and had to be met. But because the fundamental principle of the project was sound all these perplexing obstacles were surmounted. Significantly in each area, sooner or later the basic idea of the project was put to the acid test, namely, to find out if the principle of control by the local community group was really *bona fide*.

Mr. Shaw and his staff of workers on the project learned much in the process about the nature of community organization and the problem of juvenile delinquency. Three of their most important discoveries may be briefly stated:

(1) The success of the program is not to be judged so much by the decrease in the number of juvenile delinquents as by the increase in the capacity of the community to treat cases as they arise rather than in turning them over to the Juvenile Court.

(2) Indigenous leaders, or those selected from the local community, make better staff workers than trained leaders imported from the outside.

(3) Local committees of citizens, if given responsibility for conducting the project, are able to gain the moral and financial support of the community. For example, the neighborhood projects, now numbering twelve, raised \$80,000 for their support during 1952 in addition to allocations from the Community Fund. The willingness of local citizens to pay for the program is proof of its acceptance by the community.

The projects which have been in existence the longest time show a decrease in delinquency rates as compared with rates for

the entire city. Yet this decline in delinquency is perhaps less important than three other criteria of success. These are: (1) capability of a community to organize and to maintain a welfare program; (2) effectiveness in developing a plan for the treatment of delinquents in co-operation with the Juvenile Court and probation and parole supervision; (3) the degree to which local leaders can be recruited and trained for staff positions in the program; and (4) the extent to which the community gives the program its moral and financial support.

Community and neighborhood projects of this type can and should play a decisive role in a positive and preventive program of mental health. They can develop a program which will provide wholesome participation in social groups for the children and the adults of the community. The churches and the schools should take part actively in a community-wide program in which their special part is defined and outlined.

MODERN SOCIETY AND PROBLEMS OF MENTAL HEALTH

So far we have dealt with the family, the social group, the neighborhood and the local community as ways to positive mental health. We have assumed that the environing society was a constant. But it is not a constant. It is in continuous social change. What is the effect upon mental health of the rapid tempo of technological change and of the failure of our institutions to make corresponding innovations in our culture and our values?

Lawrence K. Frank in an article, "Society as the Patient," makes a brilliant statement of the role of social change and of cultural lag as causative factors in the mental difficulties and problems of adjustment of the individual:⁵

There is a growing realization among thoughtful persons that our culture is sick, mentally disordered, and in need of treatment. . . . The disintegration of our traditional culture, with the decay of those ideas, conceptions, and beliefs upon which our social and individual lives were organized, brings us face to face with the problem of treating society, since individual therapy or punishment no longer has any value beyond mere alleviation of our symptoms.

The concept of a sick society in need of treatment has many advan-

⁵ Lawrence K. Frank, "Society as the Patient," *American Journal of Sociology*, 42 (1936), pp. 335, 336, 339, 341, 344.

tages for diagnosis of our individual and social difficulties and for constructive therapy. Perhaps the most immediate gain from adopting this conception is the simplicity it brings. Instead of thinking in terms of a multiplicity of so-called social problems, we can view all of them as different symptoms of the same disease. . . . If, for example, we could regard crime, mental disorders, family disorganization, juvenile delinquency, prostitution and sex offences, and much that now passes as the result of pathological processes (e.g., gastric ulcer) as evidence, not of individual wickedness, incompetence, perversity, or pathology, but as human reactions to cultural disintegration, a forward step would be taken.

Our so-called social problems are to be viewed as arising from the frantic efforts of individuals, lacking any sure direction and sanctions or guiding conception of life, to find some way of protecting themselves or of merely existing on any terms they can manage in a society being remade by technology. Having no strong loyalties and no consistent values or realizable ideals to cherish, the individual's conduct is naturally conflicting, confused, neurotic and antisocial. . . . If we accept the conception of society as the patient, absolve the individual from guilt, and regard these various social problems as symptoms of progressive cultural change, we can at least relieve some of our anxiety since we then have a definite and possibly manageable problem.

Today we must face the task of reconstructing our culture and creating our own design for living, in which the age-old cruelties, frustrations, and deprivations may, we must hope, be mitigated, if not eliminated. For that task we have need of more understanding of personality and culture and, above all, of faith in the value of human life which the new culture must serve. Until the culture makes the conservation of human values the dominant theme, the individual cannot, or will not, find his fulfilment.

On first reading, the above statement by Frank may seem paradoxical. But upon reflection we all recognize its truth. How many problems and mental conflicts of the individual would disappear or be greatly reduced if we could make certain long-overdue changes in our culture. Cultural lag is then one cause of social and personal maladjustments. Other causes to be considered inhere in the characteristics of modern urban society, so different from those of the past.

The anthropologist points out that mental health is relative to the culture of the people. Among primitive societies, for example, psychoneuroses and psychoses as we know them are absent or occur very seldom. These societies are static. They are in adjust-

ment to life conditions. They provide satisfying roles for their members.

American society, by contrast, is dynamic and rapidly changing. It is still in transition from a rural to an urban way of life. Our national ideology with its roots in a colonial agricultural society has not been realistically modified to fit the conditions of a modern urbanized world. The result is that there exist many contradictions in our systems of values and there is often great confusion between our beliefs and our practices.

Accordingly, problems of personal unadjustment and maladjustment arise not merely from cultural lag and cultural conflict. Their causes are much more fundamental. They arise because our society is dynamic and complex and because the individual is expected to act on his own in making adjustments.

In the static societies of the past, the family made the adaptations for its youthful members. For example, in China until recently the family provided or secured a job for the son, selected a mate for him, and gave all members protection against crises. Under this system personal adjustment in childhood and youth was reduced to a minimum. There was no need for psychiatric social workers, vocational counselors, marriage advisers, sociologists, or psychiatrists.

In a dynamic society like that of the United States, change is the accepted order of events. The individual must be adaptive and creative if he is to succeed.

We cannot, if we would, go back to the simple, static, family-controlled society of the past. Change is irreversible. The tempo of change will not diminish but will increase. We must study the nature of modern society and utilize our findings about it for a positive program of mental health.

What is the nature of modern society that creates the many problems of adjustment for its members?

A complete analysis awaits further social science research. Certain main characteristics discovered by the cultural anthropologist, the economist, and the sociologist may be briefly pointed out.

1. An outstanding feature of modern society is the complexity of its economic and social organizations. The U.S. Census Bureau recognizes 50,000 different occupations. It is no easy matter for the youth to select an occupation for which he is best fitted from this multitudinous array of vocations. Then, too, American society

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is extremely heterogeneous, with subcultures by regions, by ethnic groups, and by social classes.

2. A second leading attribute of our present-day society is its increasing mechanization and standardization. Everywhere technological devices are replacing personal effort. Goods and services are becoming more and more standardized. The individual frequently feels himself at the mercy of mechanization and standardization rather than being served by them.

3. Paralleling mechanization of services and standardization of goods is the increasing secularization of our life. More and more areas of life and objects of our desire are being transferred from the sacred to the secular.

4. As a consequence of the growing complexity, mechanization, and standardization of living, impersonal relations between people are being substituted for personal relations.

It was relatively easy for the person to adjust to the simple self-sustaining rural society of personal relations in the past. It is increasingly difficult to adjust to the complex mechanized urban society of the present with its vast network of impersonal relation. Failure in adjustment leads to mental conflicts and breakdowns.

But how may these problems of adjustment be controlled with a minimum of maladjustment? Only by a positive program of mental health centered around the adjustment of persons to the modern world. Such a program must be designed to meet the complex situations of occupational roles, of mechanization, standardization, and secularization of urban life, and of the growing impersonality of social relations. It must be commensurate with the magnitude of the problem.

Economic and social security is basic in modern society. Families and individuals need to have guarantees of income sufficient for housing, for nutrition, and for health. But over and beyond that persons desire self-expression and achievement in roles through which they may discharge a distinctive function in society. In adjusting to their roles in the family, in a vocation, in marriage, in the community, all persons in modern society need assistance in greater or less degree.

Adjustment has two phases: personal and social. *Personal* adjustment means a process by which the person makes changes in his attitudes and behavior in order to achieve his own goals and meet the expectations of society or one or more of its component groups. *Social* adjustment is a change in the standards and practices of exist-

ing agencies or the establishment of new organizations better designed to satisfy the wishes and aspirations of human beings and/or to promote social efficiency. Programs of both personal and social adjustment are essential in a positive mental-health program.

Personal and social adjustment are closely correlated. Delay in social adjustment to technological change increases the problems of personal adjustment. Whenever new social adjustments are made, related personal adjustments are entailed.

New services which should be provided include counseling and guidance for success in school, in work, in marriage, and in social relations. Existing institutions like the school, the church, and other character-building agencies have important roles to play. On the basis of an understanding of the problems of persons in modern society they are beginning to reorient their programs in the direction of positive mental health. They can make a real contribution by helping develop in persons the characteristics desirable for adjustment in modern society.

The psychiatrist stresses the trait of emotional maturity as of highest value for mental health and social efficiency. The sociologist emphasizes two other traits as essential for personal development in modern society. He gives high priority to the characteristic of adaptability in view of the constant necessity of acting in new and changing social situations. Adaptability is partly genic or psychogenic in terms of individual differences in flexibility and in social insight in meeting changing conditions. It is partly social in the sense that the person can be induced by information, counseling, and training to change his attitudes and to develop new ways of acting.

The second characteristic stressed by the sociologist is that of socialization. The socialized person is one who joins with others in defining the objectives of his society and participates in the attempt to realize them. The socialization of the person takes place through social experience in group life. It differs from sociability, which is the desire to be in the company of others. It is not the same as sympathy and altruism, which are the disposition to help other people. Sociability and sympathy may, in general, be of assistance in the socializing process but they are different from it. The school and the church endeavor to socialize by inculcating values, but this method needs to be supplemented by experiences in social living. Socialization finds the best opportunities for expression in situations in the family and in intimate social groups where the

members co-ordinate their individual wishes with the objectives of the group.

One way to achieve positive and preventive mental health is to provide conditions for the development of persons who are emotionally mature, adaptable, and socialized.

In conclusion, we need to realize the profound truth of the thesis of George H. Mead that mind and society are inseparable, that they are two aspects of the same thing. Mental health is associated with a society which is functioning successfully. Mental ill health is a symptom and index of the malfunctioning of society.

Accordingly, positive and preventive ways to mental health require, as we have seen, the following:

1. Safeguarding the family by an adequate program in the schools and in churches of education for marriage and family living and by provision of more and better-equipped centers for marriage counseling.

2. Encouraging people of all ages to be members of small intimate groups and of voluntary associations in which they obtain self-expression and a sense of belonging.

3. Utilizing the neighborhood and the local community as units for programs of social welfare and mental health, thereby releasing initiative and energy at the grass roots of democracy.

4. Gaining an understanding of the new and complex urban society in which we live as the only sound basis for shaping our social organizations to fulfill the needs, the wishes, and the aspirations of human beings.

5. Strengthening and making more vital the existing services for helping people make adjustments. These include, beside marriage counseling, vocational guidance, educational counseling, and personal guidance. All these services need to be permeated with the point of view of mental health and with an understanding of the nature of modern society and its impact upon human beings.

What I am advocating is a marriage of psychiatry and sociology, of the psychological and the social sciences, in the interest of a well-rounded program of mental health. Both are indispensable. Each has a distinctive contribution to make. We must, of course, continue to expand our program of treatment of those who fail to adjust. But at the same time we must also make changes in society which will enable human beings to function effectively in our complex modern life.

The call to medical and social scientists to co-operate has been

sounded by Rennie and Woodward in their book *Mental Health in Modern Society*.⁶ They say:

Mental health cannot be developed in a social vacuum. Powerful factors operate against it as our present society is constituted. To promote positive mental health will therefore require the cooperation and help of many individuals and groups. Medical and social scientists need to look squarely at these factors and, abandoning professional isolation, cooperate in an attempt to counteract them. Mental health can only be achieved in an environment which provides opportunities for self-expression, social usefulness, and the attainment of human satisfactions. Preventive psychiatry is only beginning, and its only sure tool at present lies in educating the public in the meaning and causes of mental disorders and the ways of developing positive mental health.

⁶ T. A. C. Rennie and L. E. Woodward, *Mental Health in Modern Society*. New York. Commonwealth Fund (1948), p. 385.

TWO

Interactions of Psychiatric and Social Theory Prior

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THE purpose of this chapter is to review the beginnings of intellectual cross-fertilization on the frontiers between psychiatry and the social sciences (sociology, social psychology, social anthropology, social economics). The principal interest has been to explore and record chronologically contributions of "sociology" to psychiatric thinking, but it has not proved easy to unscramble the two-way influences observable in many of the writings throughout this period. If a psychiatrist discovers cultural factors and proceeds to evolve social theory, it may be as good evidence of sociological contribution to psychiatry as if it had been written by a man with a Ph.D. in sociology. Similarly, if an economist, or religionist, or art critic (for example) applies psychiatric concepts to special areas of social behavior, or, vice versa, sociological concepts to psychopathic behavior, he serves as a sociological bridge between the disciplines. For the most part this review stresses those contributions which have interpreted "psychiatry" in sociological context, or "mental illness" arising in social situations, rather than those which merely used psychoanalytic concepts to explain "normal" conduct.

Psychiatry and the theories of psychiatrists have achieved great prestige in recent years among sociologists and social workers. But, within the medical profession itself, the history of psychiatry is that of a heretic suspect, a minority group. Long before psychiatry was heard of, *neurology* first won recognition as a specialty. The majority of psychiatrists approached their present work through the study and practice of neurology, and many of the older men still give evidence of their earlier training. They are thereby biased in the direction of purely "physical" interpretations

* Prepared especially for this volume.

of mental diseases based upon functional or organic defects of the individual—if not completely “color-blind” to social factors. Thus, insanities tend to be classified and diagnosed in a manner comparable to that used for the far more specific syndromes of infectious and degenerative diseases. Psychiatrists of certain schools, Kraepelinian and Kretschmerian, further stress organismic types; but they tend to satisfy themselves with and in the process of classification, with only minor recognitions of interpersonal, societal, and cultural factors in the insanity situations. But even this degree of emancipation from mere neurology was at first grudgingly recognized in conservative medical circles.

Like the earlier psychiatrists, psychoanalysts had their battles for recognition, even for recognition by their brother psychiatrists. There is a sense in which all physicians who diagnose exclusively in terms of the individual are merely reflecting the individualism of their culture and the semantic limitations of their language structure. Most people naively think of behavior, relations, and social situations in terms of personal “traits,” but such “traits” are abstracted from the complex of actual events in which both the observed and the observer are interacting participants in a “field.” Personal “traits” are actually observed consistencies and persistencies of behavior, abstracted from total behavior, labeled, and attributed to the person as if independent of the interactive situations in which they emerge. Mental disease, criminality, etc., have thus been considered and treated as “traits.”

To view insanity (the legalized diagnosis) and mental diseases (the medical diagnosis) as *situations* rather than as merely individual traits became an observable trend among sociologists and other social scientists, and among psychiatrists and psychoanalysts, of the period we are reviewing.

Thorstein Veblen and Simon Nelson Patten, who might be called psychological economists, had interpreted in the light of social situation-processes the motives of consumers,¹ of business men,² of craftsmen,³ of engineers,⁴ etc. Many of the motives thus analyzed had previously been considered blameworthy if not pathological.

¹ Veblen, Thorstein, *The Theory of the Leisure Class* (New York: Macmillan, 1899).

² Veblen, *The Theory of Business Enterprise* (New York: Scribner, 1904).

³ Veblen, *The Instinct of Workmanship* (New York: Macmillan, 1914).

⁴ Veblen, *The Engineers and the Price System* (New York: Huebsch, 1921).

Patten⁵ attributed the enjoyment of revivalism to its outlet for repressed desires. He recognized the repressive character of traditional moralities and advocated a morality of released energy and positive goals. He also saw the wish-fulfilling character of certain theologies and religious crusades, and contrasted the religions of consolation or escape with those of protest, power, and productivity. These interpretations run parallel to those of Jung and other psychoanalysts, though no contact is apparent.

Carleton W. Parker, a socially and psychologically oriented labor economist, utilized the then popular McDougall battery of instincts and the theories of frustration and scapegoating then current to interpret the negativistic behavior and ideology of radical workers' groups on the Pacific Coast.⁶ These analyses contributed further, therefore, to the social-situational approach to behavior and its motivation.

Another labor manager and personnel administrator, Ordway Tead, also used the "instincts" but interpreted "normal" work behavior and employee-employer situations.⁷ This was a forerunner of recent studies in the "sociology of the job."

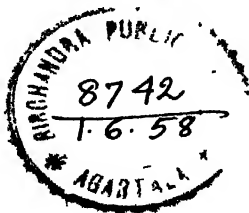
But, like the discoveries of Eric the Red and of Leonardo, the potential contributions of such men as Veblen, Patten, and Parker to psychiatric theory remained as "stored stimuli," unrecognized until rediscovered in the light of later discoveries—and still unknown to most psychiatrists.

Sociologists must yield chronological priority to certain psychiatrists and psychologists when it comes to the application of psychoanalytic concepts to social behavior. It was a psychiatrist who once said "every neurosis involves a social relationship; no neurotic conflict is without a moral factor." Until sociologists had explored the theories and tested the analytic tools of psychiatrists, they could hardly be expected to contribute to psychiatric theory either positively or by adverse criticism.

⁵ Patten, Simon Nelson, *The New Basis of Civilization* (New York: Macmillan, 1910); *The Development of English Thought* (New York: Macmillan, 1899); *The Social Basis of Religion* (New York: Macmillan, 1911); and other writings.

⁶ Parker, Carleton, "The California Casual and His Revolt," *Quarterly Journal of Economics*, XXX (March, 1918), 110-126; "The I.W.W.," *Atlantic Monthly*, CXX (November, 1917), 651-662, "Motives in Economic Life," *Publication of the American Sociological Society*, XII (1918), 131-151; *The Casual Laborer* (New York: Harcourt, Brace and Howe, 1920).

⁷ Tead, Ordway, *Instincts in Industry* (Boston: Houghton, 1918).



During the period with which we are here especially concerned (1915-1940) the preponderant currents were from psychoanalysis to the social sciences rather than from sociology to psychiatry. Yet in recording the latter contributions one should not fail to note certain writings by certain psychiatrists.

Freud himself had pointed the way in *The Psychopathology of Everyday Life*,⁸ and *Reflections on War and Death*.⁹ (*Totem and Taboo*¹⁰ and Geza Roheim's writings¹¹ were further ventures, but based upon now-rejected anthropological theories.)

Certain psychoanalysts were recognizing the cultural or situational factors in the neurosis and psychoses, and in non-sociological terms functioned as sociologists to other psychiatrists. Such were Alfred Adler, William Healy, Charles MacFie Campbell, William Alanson White, Edward J. Kempf, Trigant Burrow, Franz Alexander, Harry Stack Sullivan, James Plant, Frankwood Williams, Karen Horney, Gregory Zilboorg, Mandel Sherman, and David Slight.¹²

Meetings and publications of social workers and social scientists at which such psychiatric thinkers were heard not only readied an increasing number of sociologists for the transfer of psychopathic "mechanisms" to the analysis of "normal" social behavior, but alerted both psychiatrists and sociologists to the actual and potential values of their own and the others' reciprocal contributions. While there was (and still is) some tendency for psychiatrists to rediscover and naively rename social-situational aspects of their clinical entities and syndromes, in the years 1920-30 the writings of these "sociologized" psychiatrists begin to show, in their concepts, perspectives, and specific citations, positive evidence of reciprocal cross-fertilization.

The writer's assignment for this volume was limited to American theorists, and did not include the contributions of psychiatrists to sociological theory and analysis. Omitted, therefore, are many significant papers in this border-field. The few exceptions are such

⁸ A. A. Brill (tr.) (New York: Macmillan, 1914).

⁹ A. A. Brill and A. B. Kuttner (tr.) (New York: Moffat, Yard, 1918).

¹⁰ A. A. Brill (tr.) (New York: Moffat, Yard, 1918).

¹¹ Roheim, Geza, *Australian Totemism: A Psycho-analytic Study in Anthropology* (London, George Allen Unwin, 1915).

¹² Cf. in this connection the special symposia, *American Journal of Sociology*, XLII (May, 1937, with bibliography 892-894) and XLV (November, 1939).

as seemed especially significant in their stimulation of sociologists' contributions, and such selection may suffer from shortcomings of the reviewer's judgment. This volume, furthermore, is primarily concerned with sociological rather than with other social-science contributions; therefore the utilization and criticisms of psychoanalytic theories by anthropologists and political scientists, for example, have not been covered. At the same time, there have been several writers whose own role, as between sociology and neighboring disciplines, has been ambiguous, such as Veblen, Parker, Wolfe, Young, Cooper, Zorbaugh, Krout, Boisen, Frank, and Lasswell, whose contributions to the study of psychiatric situations are sociological or social-economic or social-psychological; and certain of these borderline men are cited.

One should not ignore such contributions to both sociological and psychiatric thinking as those of Edwin B. Holt (psychologist),¹³ perhaps the first in U.S.A. to link both behavioristic and social-moral implications to psychoanalytic theory; the single paper of Virgil Jordan (a journalist and economist), "The New Psychology and the Social Problem";¹⁴ and Everett Dean Martin (a social psychologist), *The Behavior of Crowds*¹⁵ and *The Mystery of Religion*.¹⁶

The present résumé of the literature will refer to each contributor in the order of his first known relevant publication, and proceed to his later relevant contributions, if any (up to 1940), before taking up the author whose first published relevant work immediately followed the previous writer's first. This seemed a less confusing arrangement than a strictly chronological list of all contributions by all the authors.

The earliest sociologists to publish their recognition of the insights into "normal" and group behavior provided by psycho-

¹³ Holt, Edwin B., *The Freudian Wish and Its Place in Ethics* (New York: Holt, 1915).

¹⁴ Jordan, Virgil, "The New Psychology and the Social Problem," *Dial*, LXVII (November 1, 1919), 365.

¹⁵ Martin, Everett Dean, *The Behavior of Crowds* (New York: Harper, 1920). This book interpreted the "crowd" in Freudian terms as a state of mind permitting behaviors which in separate persons would be psychopathic if not repressed. His observations were made among the numberless audiences of Cooper Union, in New York City. Crowd-mindedness was considered psychopathic, and extended to all victims of mass media as "quasi-crowds."

¹⁶ Martin, Everett Dean, *The Mystery of Religion* (New York: Harper, 1924).

analytic concepts and theories were Ernest Rutherford Groves and William Fielding Ogburn. In 1916 Groves had recognized the importance of psychoanalysts' diagnostic, interpretive, and therapeutic concepts for counseling by non-medical professions such as the clergy.¹⁷ This did not point up the significance of psychiatric theory for social theory: it was mental hygiene or social psychiatry rather than psychiatric sociology. But his 1917 paper shifted the interest from pastoral therapy to sociological theory. Groves recognized in some religions, as had Patten, those aspects which could serve persons as a channel for escape or fantasy-satisfaction: the "narcotic" element¹⁸ in mysticism, asceticism, martyrism, renunciation, isolation, nirvana. Groves reanalyzed the socialization process and the social problems of family living in psychoanalytic terms, and in so doing helped to expand the potential focus of the psychiatrists' case-unit, from the mere individual organism to the social situation in which the person operated. There is an analogy here to what Richard Cabot did in expanding physical diagnosis to include social situational facts ("The Foreground of the Patient" and "The Background of the Patient"),¹⁹ sociosomatic facts (occupational and economic), and ethical-psychological facts.

Groves' 1917 paper is a milestone:²⁰ the first vigorous bid for other sociologists' recognition of the significance of Freud's (and his disciples') theories and insights (especially the reality and pleasure principles and sublimation theory) for the interpretation of general social behavior. While he himself continued to be in-

¹⁷ Groves, E. R., *Moral Sanitation* (New York: Association Press, 1916). Groves was influenced by Trigant Burrow's "Psychoanalysis and Society," *Journal of Abnormal Psychology*, VII (December, 1912), 340-350.

¹⁸ Groves, E. R., "Freud and Sociology," *Psychoanalytic Review*, III (July, 1916), 241-253; "The Unsocial Element in Religion," *American Journal of Sociology*, XXII (March, 1917), 657-662. The latter paper is more hortatory than research-oriented, but it has theoretical implications. Also see Groves' chapter on "Mental Hygiene and Religion" in Groves and Blanchard, *Introduction to Mental Hygiene* (New York: Holt, 1930), 306-42.

¹⁹ Cabot, Richard, *Social Science and the Art of Healing* (New York: Moffat, Yard, 1917); *Social Work . . . Doctor and Social Worker* (Boston: Houghton, 1919). Cabot's work (with others', of course) led to the general acceptance of hospital social service and psychiatric social work.

²⁰ Groves, Ernest R., "Sociology and Psycho-analytic Psychology," *American Journal of Sociology*, XXII (July, 1917), 107-116. See also "The Sociological Significance of Psycho-analytic Psychology," *Papers and Proceedings of the American Sociological Society*, XV (1920), 203-205.

terested chiefly in preventive therapy and family-life education, he developed his ideas considerably in a later book ²¹ with some general theoretical implications. In the revision of *Personality and Social Adjustment* (1931) Groves abandons the term "instinct," and continues to develop the psychoanalytic concepts of repression, multiple personality, rationalization, compensation, ambivalence, fantasy-thinking, sublimation, intro- and extroversion, fixation, identification, parent-image, and complexes (notably the inferiority complex), as interpretive tools, basing aspects of his work on the ideas of Adler, Bjerre, Burrow, White, Williams, Jung, Rivers, Shand, Tansley, and others, as well as Freud. Without underestimating sex, Groves showed at least as much appreciation of those dynamic "mechanisms" of action which require no sexual explanation.

In 1933 ²² and 1935 ²³ Groves summarized the to-then influences of psychiatry on sociology: (1) The approach to culture through psychoanalytic experience, (2) The analyzing of social situations, (3) Consideration of social problems as products of psychopathic maladjustments, (4) Recognition of endocrine factors, (5) Clinical psychiatry, the functional study of mental-disease situations. The disproportionately small contribution of sociology to psychiatry was noted, but as profitable leads he suggested the social-psychiatric investigation of the normal socialization process, the sources of neuroses in factors of the social environment, and the socioanalysis of cultural antagonisms. All three of these lines have proved fruitful.

Ogburn had been much intrigued by Parker's work (1915), but shifted from the type of economic motivation offered by Parker (cited above) to something a bit more psychoanalytic. His first paper in the border field suggested a reinterpretation of the "economic interpretation of history" in terms of the psychoanalytic mechanisms of repression and rationalization. ²⁴ Publicized motives

²¹ Groves, E. R., *Personality and Social Adjustment* (New York: Longmans, 1923; also Rev. Ed. 1931).

²² Groves, E. R., "The Development of Social Psychiatry," *Publication of the American Sociological Society*, XXVII (1933), 1943-44 (abstract).

²³ Groves, E. R., "The Development of Social Psychiatry," *Psychoanalytic Review*, XXII (January, 1935), 1-9.

²⁴ Ogburn, William F., "The Psychological Background for the Economic Interpretation of History," *American Economic Review*, LX Supplement (March, 1919), 291-308.

must be respectable, and the announced religious, moral, patriotic, libertarian, scientific, etc., motives, however actual, may have been inadequate without an underlying economic drive. Or, an ostensible economic motive may itself conceal an underlying but "censored" drive for recognition, power, etc. In "Bias, Psychoanalysis, and the Subjective in Relation to the Social Sciences"²⁵ Ogburn related the biases of social scientists to possible complexes and repressions, personal or cultural, and compared them to popular stereotypes, fantasy-thinking, dreams, and myths, as varieties of projective wishful thinking.

In 1926 Ogburn reviewed the contributions, actual and potential, of psychiatry to social psychology:²⁶ a new hypothesis of personality growth and structure; the "abnormal" as a magnification of the normal; the applicability of some "mechanisms" to "normal" as well as "abnormal" situations; the conception which I have elsewhere called "socio-somatic"; the culture-personality nexus; the role of wishful thinking in reality-distortion; and the genetic analysis of prejudices. He also suggested the role of sociologists as testers of the non-controlled (and challenged) findings or hypotheses of the psychoanalysts.

Thomas' famous "Methodological Note"²⁷ introduced the social-situational interpretation of motivation as contrasted with the instinctual or internal interpretation. While it has been criticized as truncated and inadequately elaborated, his situational theory of action and motive should be recognized as having chronological priority, in American sociology at least, over the later (and in the writer's opinion overrated) formulations of Kurt Lewin and Talcott Parsons. Thomas recognized the strains placed by social change and migration upon personal integration, and (by corollary) their effects in "mental disease" or "delinquency" situations. Kimball Young claimed that Thomas' classification of goals or satisfactions as the "wishes" was influenced by Freud.

In 1919 occurred the first American Sociological Society Roundtable on the sociological implications of psychiatry, with contribu-

²⁵ *Publications of the American Sociological Society*, XVII (1923), 62-74.

²⁶ "The Contributions of Psychiatry to Social Psychology," *Papers and Proceedings of the American Sociological Society*, XXI (1927), 82-91.

²⁷ Thomas, William Isaac, and Znaniecki, Florian, *The Polish Peasant* (Chicago: University of Chicago Press, 1918). Now in part repudiated by Znaniecki.

tions by E. R. Groves,²⁸ Edith R. Spaulding, William Alanson White, Phyllis Blanchard, Clarence Robinson, and Iva Peters.²⁹

Thomas D. Eliot's first paper³⁰ was an effort to apply concepts found in the works of Freud, Jung, Jelliffe, White, Pfister, *et al.*, to the motivation of group formations, group-joining, and behavior in groups. Later essays³¹ dealt with "insanity" as a social situation rather than as a trait, and with the cultural defining of "mental disease" situations; with situational causation and therapies of "mental diseases";³² with evidence of the operation of psychiatric "mechanisms" (especially identification) in all the so-called normal behaviors;³³ and with the possibilities of collective therapy through cultural changes.³⁴ For such studies he coined the term "socioanalysis" (1920), and the phrase "psychiatric sociology,"³⁵ comparable with "biological," "political," etc., sociologies and distinguishable from "social psychiatry," which refers to *applied techniques* in mental hygiene, psychiatric social work, etc. With combined theoretical and therapeutic interest he also utilized both

²⁸ *Loc. cit.*

²⁹ *Papers and Proceedings of the American Sociological Society*, XV (1920), 203-216. Dr. Peters prophesied increasing radicalism and psychopathic behavior, personal and mass, under the impact of cultural conflict, cultural change, cultural lags, and mass media.

³⁰ "A Psychoanalytic Interpretation of Group Formation and Behavior," *American Journal of Sociology*, XXVI (November, 1920), 332-52. Although for several years employed in the social hygiene movement, Eliot did not utilize the specifically "sexual" interpretations associated with psychoanalysis, as have certain other sociologists.

³¹ "A Limbo for Cruel Words," *Survey*, XLVIII (June 15, 1922), 389-91; "Insanity Relativity, and Group Formation," *Open Court*, XLII (May, 1928), 303-14.

³² "Cures and Cure-alls," *Journal of Abnormal and Social Psychology*, XXIII (April-June, 1928), 67-81.

³³ Cf. "Die Verwendbarkeit Psychiatrischer Bezeichnungen bei der Analyse des Sozialen Verhaltens," *Kölner Vierteljahrshefte für Soziologie*, VII (Heft I, 1928), 31-44; "The Use of Psychoanalytic Classification in the Analysis of Social Behavior: Identification," *Journal of Abnormal and Social Psychology*, XXII (April, 1927), 67-81; abstracted in *Papers and Proceedings of the American Sociological Society*, XXI (1927), 185-90.

³⁴ "The Possibilities of Cultural Hygiene," *Psychiatry*, VI (February, 1943), 83-88.

³⁵ In 1928 he gave what was, so far as known, the first course in this border-field of theory, at the University of Washington. Cf. also "Psychiatrische Soziologie und Soziologische Psychiatrie," *Kölner Vierteljahrshefte für Soziologie*, IX (Heft 1/2, 1930), 82-100.

social processes and "psychoanalytic mechanisms" in the analysis of adjustment in bereavement situations.³⁶ On the critical side he contributed a sociological appraisal of the theories of Trigant Burrow,³⁷ a psychiatrist who considered civilized culture as collectively insane, recognizing social causation of psychopathy in everyone.

Walter S. Swisher, a minister but not a sociologist, analyzed the historic religions, their theologies, their rituals, their typical experiences of conversion, salvation, etc., in psychoanalytic terms, but as cultural and social-organizational channelizations of emotional tensions.³⁸

Anton Boisen, a sociologist serving as a chaplain, studied religious ideologies, ethical conflicts, and social life histories as factors of causation or therapy in institutionalized mental patients. He was a steady and useful contributor from 1922 on.³⁹ Boisen sees ethical and religious conflicts as hopeful symptoms like fever or

³⁶ "The Bereaved Family," *Annals of the American Academy of Political and Social Science*, CLX (March, 1932), 184-90.

³⁷ "The Social Philosophy of Trigant Burrow," *Mental Hygiene*, XII (July, 1928), 530-548.

³⁸ Swisher, Walter S., *Religion and the New Psychology: A Psychoanalytic Study of Religion* (Boston: Marshall Jones Co., 1920).

³⁹ Boisen, Anton, "Concerning the Relationship between Religious Experience and Mental Disorder," *Mental Hygiene*, VII (April, 1923), 307-11; "Evangelism in the Light of Psychiatry," *Journal of Religion*, VII (January, 1927), 76-80; "The Sense of Isolation in Mental Disorders . . .," *American Journal of Sociology*, XXXIII (January, 1928), 555-67 (social factors in 176 cases); "A Psychiatric Approach to the Study of Religion," *Religious Education*, XXIII (March, 1928), 201-7. (In 45 "dementia praecox" patients classified by sex, vocation, and social maladjustment, failure to live up to their own accepted standard was conspicuous.) "The Study of Mental Disease as a Basis for Program of Moral and Religious Education," *Religious Education*, XXIII (April, 1928), 373-380; "The Experiential Aspects of Dementia Praecox," *American Journal of Psychiatry*, XIII (November, 1933), 543-78; "The Problem of Values in the Light of Social Pathology," *American Journal of Sociology*, XXXVIII (July, 1932), 51-63; *The Exploration of the Inner World* (Chicago: Willett, 1936)—disorder as an attempted reorganization or compensatory adaptation that misses fire: a philosophy of life plus a sense of failure. "Religion and Hard Times: A Study of the Holy Rollers," *Social Action*, V (March 15, 1939), 8-35 (reprinted in Schuler, Edgar, et al., *Outside Readings in Sociology* (New York: Crowell, 1952), 430-439; "Economic Distress and Religious Experience: A Study of the Holy Rollers," *Psychiatry*, II (May, 1939), 185-941—Cults serve loneliness: There is a shared quest for solutions. Their behavior patterns resemble those of certain psychoses: There is escape from the actual.

inflammation, and finds improvement through relief of isolation, of guilt feelings, and of fears.

Being a behavioristic social psychologist, L. L. Bernard appeared in this area as a critic of the ideas of several psychiatric theorists (Freud, Jung, McCurdy, Jelliffe, etc.), especially in the interpretation of neuroses.⁴⁰ He advocated social organization for sublimation to reduce internal conflicts.

One notes that the use of psychopathological concepts to characterize *collectivities* (a form of the group fallacy or organismic analogy) was eschewed by our writers and we shall omit such pseudo-contributions. Nor was there in the papers thus far cited any explicit elaboration of the sexual concepts most frequently associated with Freud's name.

In 1923, Kimball Young, as a psychologist, recognized "the difficulties of personal integration in a dissociated cultural milieu. Repressions could represent a social waste of energy, as well as a source of neurosis. He utilized the psychoanalytic concepts of suppressed wishes, ambivalence, projection of guilt upon scapegoats, defense mechanisms, and compensation mechanisms for guilt or frustration, and he suggested forms of education such as would recognize and resolve such difficulties. His credited sources, except for Jung, were not psychiatric. In 1926 Young published a paper on "The Psychology of Hymns"⁴² in which psychoanalytic interpretations were used, and the compensatory, palliative, or cathartic functions of their words was pointed out. Young's paper, "Parent-child Relationship: Projection of Ambition,"⁴³ dealt with intrafamily identification and proxy wish-fulfillment as causes of internal emotional conflict. In the first Colloquium on Personality Investigation, held under the auspices of the American Psychiatric

⁴⁰ Bernard, L. L., "A Criticism of the Psychoanalytic Theory of the Libido," *Monist*, XXXIII (April, 1923), 240-71; "Psychoanalysts' Theory of the Conflict Neurosis," *American Journal of Psychology*, XXXIV (October, 1923), 511-30.

⁴¹ Young, Kimball, "The Integration of the Personality," *Pedagogical Seminary*, XXX (September, 1923), 264-85. Young may have introduced into psychiatric sociological literature the tendency to use "projection" to refer only to imputation of motives or attributes, and to contrast it with "identification." Psychiatrists had used "projection" as the opposite of "introjection," both processes being complementary *phases* of the general process of identification.

⁴² *Journal of Abnormal Psychology*, XX (January, 1926), 391-406. (Infantile return, masochistic and sadistic projection.)

⁴³ *The Family*, VIII (May, 1927), 67-73.

Association's Committee on Relations with the Social Sciences,"⁴⁴ Young discussed *autistic thinking*.

Young's 1930 paper, "The Contribution of Psychiatry to the Study of Group Conflict,"⁴⁵ based directly on Freud as then known, gives psychoanalysis credit for revealing the importance of infantile pre-cultural but already social interaction which Young dubbed "personal-social." But his critique had reciprocal significance for psychiatry. In 1931 Young criticized *Psychopathology and Politics* of Lasswell (whom he had previously cited favorably).⁴⁶ Later, a number of Young's ideas in the field were drawn together in the last chapter of his *Personality and Social Adjustment*.⁴⁷

Frank Tannenbaum, labor economist, himself once imprisoned for leading a demonstration of the unemployed, utilized psychoanalytic insights in the interpretation of prison behavior⁴⁸ and of small-town lynching in the "Deep South."⁴⁹ In so doing he indicated, by implication or otherwise, social-situational factors in certain psychopathic and sociopathic behaviors, and possible measures of "cultural hygiene" for them.

Earl D. Myers, in his master's thesis,⁵⁰ traced the history of three major group fissions (The Protestant Reformation, The Progressive Party, and The Clothing Workers) in relation to the divided loyalties stimulated by current events. The paper was documented with biographical materials about Martin Luther, Theodore Roosevelt, and Sidney Hillman.

Several sociological writers about this time (1922-23) recognized the psychic mechanisms probably underlying at least the emotional reactions of radicals, reactionaries, and social reformers, though none attempted actual psychoanalysis of such people. Myers and Martin have already been mentioned. Ellery Reed,⁵¹ Iva

⁴⁴ December 1-2, 1928, New York City, sponsored by the Laura Spelman Rockefeller Foundation.

⁴⁵ *Publication of the American Sociological Society*, XXV (May, 1931), 111-124.

⁴⁶ "Recent Contribution of Psychoanalysis to Political Science," *Journal of Abnormal Psychology*, XXV (January, 1931), 465-473.

⁴⁷ (New York: Crofts, 1940).

⁴⁸ Tannenbaum, Frank, *Wall Shadows: A Study in American Prisons* (New York: Putnam, 1922).

⁴⁹ *Darker Phases of the South* (New York: Putnam, 1924).

⁵⁰ Myers, Earl D., "Some Effects of Internal Psychic Conflicts in the Rise of Institutional Secessions" (unpublished), Northwestern University, 1923.

⁵¹ Reed, Ellery, "Psychic Mechanisms and Social Radicalism," *Journal of*

Peters,⁵² Stuart Rice (who had himself recently been leader in a labor party),⁵³ and Albert Benedict Wolfe (a welfare economist and sociologist)⁵⁴ all made keen observations in this field.⁵⁵

Herbert Adolphus Miller⁵⁶ coined the phrase "oppression psychosis" for the typical reactions of minority peoples. Since the original meaning of psychosis is merely "a state of mind," not necessarily "diseased," this usage is unobjectionable as applied to a number of persons subjected to and compensating against similar insecurities, shocks, strains, and threatened status. Miller does not commit the organismic fallacy of calling a nation or other collectivity psychopathic as such, as if it were a super-individuality. He also showed the use of religious transference or substitution when a people is deprived of political continuity.⁵⁷

Elton Mayo, a social psychologist of industry, began contributing to the field in a semipopular, hortatory fashion about 1923. He recognized repression, compensation, etc., in both "normal" and "psychopathic" personalities both as causes and as effects of industrial and educational organization (or disorganization); also the positive as well as negative potentialities of "revery."⁵⁸ He also

Social Forces, II (November, 1923), 36-40—Transference, defense, compensation, etc.

⁵² Peters, I, *Loc. cit. supra*. Cf. also "The Concept of Repression in the Analysis of Problems of the Family," *Journal of Applied Sociology*, VII (July, 1923), 309-17.

⁵³ Rice, Stuart, "Motives in Radicalism and Social Reform," *American Journal of Sociology*, XXVIII (March, 1923), 577-85.

⁵⁴ Wolfe, A. B., "Emotion, Blame, and the Scientific Attitude in Relation to Radical Leadership and Method," *International Journal of Ethics*, XXXII (January, 1922), 142-59, "Conservatism and Radicalism . . ." *Scientific Monthly*, XVII (September, 1923), 229-37; *Conservatism, Radicalism, and Scientific Method* (New York: Macmillan, 1923), *passim*. This is a book which should not lie unused in these days. Reading of this and similar analyses have been admittedly effective in bringing objective insights to certain "radical" students.

⁵⁵ A later bit of empirical research was contributed by M. Krout, whose work is sketched later. He found a proportion of *parental rejection* situations among radicals greater than among non-radicals. "A Controlled Study of the Development and Attitudes of Radicals," *Psychological Bulletin*, XXXIV (November, 1937), 706-707 (abstract). See also Maurice Krout and Ross Stagner, "Personality Development in Radicals," *Sociometry*, II (January, 1939), 31-46.

⁵⁶ Miller, H. A., "The Oppression Psychosis," in *Races, Nations and Classes* (Philadelphia: Lippincott, 1924), 32-38.

⁵⁷ "Religion's Entangling Alliances," *op. cit.*, 39-58.

⁵⁸ Mayo, Elton, "Civilized Unreason," *Harper's Magazine*, CXLVIII

noted the role of some religious moralizing and semantic "black-white orientations" or false dichotomies, in producing certain guilt-neuroses.⁵⁹ Later⁶⁰ he generalized on the relation of the Freudian psychiatric theory of neuroses to sociology wherever social causes produce or accentuate personal pathology: Freud himself discovered that society is implicated in psychoneuroses. Psychiatry is intimate sociology—but as such it needs new interviewing categories.

As a creative contribution to interdisciplinary theory the work of Lawrence K. Frank, which began to appear in 1927, has been insufficiently recognized. With orientations in sociology, economics, education, and philosophy of science he combined wide knowledge and insights in psychiatry, physiological psychology, and culture.⁶¹ His "psychocultural approach" was and is *socio-psychosomatic*. A keen theorist, he has always shown concern for human values and for what I have dubbed "cultural hygiene."⁶²

What is probably Frank's best-known paper appeared in 1936, stating cogently a definition of the total psychopathological situation long familiar to criminologists and to psychiatrists: not "Society is to blame," but "Society as the Patient."⁶³ Individual breakdowns, like delinquencies,⁶⁴ are indices of general cultural disintegration. But society is diagnosed not as a superself, but as an interactive unity through which its members are served, and is

(March, 1924), 527-35; "Civilization—The Perilous Adventure," *Harper's Magazine*, CLII (July, 1925), 225-33.

⁵⁹ "Sin With a Capital S," *Harper's Magazine*, CLIV (April, 1927), 537-45.

⁶⁰ "Psychiatry and Sociology in Relation to Social Disorganization," *American Journal of Sociology*, XLII (May, 1937), 825-31.

⁶¹ Frank, Lawrence K., "Physiological Tensions and Social Structure," *Publications of the American Sociological Society*, XXII (1927), 74-83. (Not specially psychoanalytic but showing thought paralleling that of Edward J. Kempf's *The Autonomic Functions and the Personality*, Nervous and Mental Disease Monograph Series, No. 28 (Washington: Nervous and Mental Disease Publishing Co., 1921).)

⁶² Frank, L. K., "The Management of Tensions," *American Journal of Sociology*, XXXIII (March, 1928), 705-36; "The Reorientation of Education to the Promotion of Mental Hygiene," *Mental Hygiene*, XXIII (October, 1939), 529-43.

⁶³ Frank, Lawrence K., *American Journal of Sociology*, XLII (November, 1936), 335-44. Cf. indictments of society as pathological by Triggant Burrow, Frankwood Williams, Samuel Schmalhausen, et al.

⁶⁴ Cf. Thomas D. Eliot, *The Juvenile Court and The Community* (New York: Macmillan, 1914), 186-191, the idea being credited to Roger Nash Baldwin.

therefore judged by its members' satisfactions. (This essay later appeared as the title piece in a collected volume⁶⁵ with other brilliant and fundamental philosophic analyses, including several in psychiatric sociology.) To the extent that we no longer consider our value-systems rigid, we can ask what social changes will maintain orderly control and yet prevent mental diseases.⁶⁶ Yet our most creative minds are not widely accepted and influential because they offer no scapegoating for our frustrations.⁶⁷ Sanity is no longer something given which we may lose: it is a goal to be achieved.⁶⁸

The late Ethel Sturges Dummer, a unique thinker and inspirer of cross-disciplinary thought, exploration, and experiment, sponsored a symposium on personal and social implications of "the unconscious," in which she and William I. Thomas assembled a galaxy of rising stars of notable magnitudes; for example: C. M. Child, Kurt Koffka, W. I. Thomas, John B. Watson, Edward Sapir, Marion Kenworthy, and William Alanson White. The papers were published as a volume⁶⁹ in which not the least valuable contribution is the brilliant introduction by Mrs. Dummer.⁷⁰

In 1929 William I. Thomas, who had been impressed by the potentialities of cross-disciplinary study in psychiatric-social theory, was instrumental in having introduced into the program-structure of the American Sociological Society⁷¹ a section on Sociology and Psychiatry, under his own chairmanship, to which he invited psychiatrists Harry Stack Sullivan,⁷² James L. Plant,⁷³

⁶⁵ *Society as the Patient* (New Brunswick: Rutgers University Press, 1948).

⁶⁶ Frank, Lawrence K., "Cultural Coercion and Individual Distortion," *Psychiatry*, II (February, 1939), 11-27, "The Reorientation of Education to the Promotion of Mental Hygiene," *Mental Hygiene*, XXIII (October, 1939), 529-43; "Freedom for the Personality," *Psychiatry*, III (August, 1940), 341-9.

⁶⁷ "The Dilemma of Leadership," *Psychiatry*, II (August, 1939), 343-361.

⁶⁸ "The Adolescent in a Changing World," *Journal of School Health*, X (May, 1940), 157-164.

⁶⁹ Ethel S. Dummer (Ed.), *The Unconscious: A Symposium* (New York: Knopf, 1928).

⁷⁰ Cf. also Ethel S. Dummer, *Why I Think So* (Chicago: Clarke-MacElroy, 1937).

⁷¹ Abstracts of the papers hereunder appear in *Publication of the American Sociological Society*, XXIV (May, 1930), 281-286.

⁷² "The Sociogenesis of Homosexual Behavior."

⁷³ "The Effect of Population Concentration on Temperament."

Adolph Meyer, Benjamin Karpman,⁷⁴ and Trigant Burrow,⁷⁵ also George E. Partridge.⁷⁶ Thomas himself contributed only as a catalytic agent, without presenting specific papers in the field.

In 1930 the A.S.S. section proceeded under Thomas' leadership,⁷⁷ but included more practitioners and sociologists than psychiatrists: Florence Beaman, Louis Wirth,⁷⁸ Lowell Selling, Mrs. Ethel S. Dummer, E. W. Burgess, C. E. Gehlke, Kimball Young,⁷⁹ Robert E. Park, Herbert Blumer. Park⁸⁰ pointed to the investigation of cultural conflicts for light upon functional disorders. In 1931 the chairmanship passed to Ellsworth Faris, but the program was still Thomas'. Sullivan and Plant⁸¹ appeared again, with recognitions of the impacts of urban crowding on children's emotional problems, and Sapir spoke on "The Relations between Cultural Anthropology and Psychiatry."⁸² He brushed off the race unconscious as a psychiatric "mystery," but stressed the profound influences of cultural continuities and cultural shortcomings upon resistant individualities.

In 1932 Eliot took the chairmanship of the section, with papers by Groves and by Folsom, who will be mentioned later; one session was devoted to the cultural patterning of "psychotic" states peculiar to certain cultural areas. Contributing were John Cooper,⁸³ Irving Hallowell,⁸⁴ Margaret Mead. In 1933 the emphasis shifted to the mental hygiene of industry. Shortly thereafter the general program structure dropped the section.

⁷⁴ "Notes on the Psychopathology of Crime."

⁷⁵ "So-called 'Normal' Social Relationships Expressed in the Individual and the Group, and Their Bearing on the Problems of Neurotic Disharmonies."

⁷⁶ "Sociologic Implications of Psychopathic Personality." Partridge introduces the term "sociopathic."

⁷⁷ "Cultural Factors in Mental Deviation and Delinquency" and "Relations of Psychological Conflict and Group Conflict." (Social Conflict was the theme of the year's meetings.)

⁷⁸ "Culture Conflict and Misconduct."

⁷⁹ "Contribution of Psychiatry to the Study of Group Conflict," *Publication of the American Sociological Society*, XXV (May, 1931), 111-124; discussed above.

⁸⁰ "Personality and Culture Conflict," *loc. cit.*, 95-110.

⁸¹ "Cultural Patterns as Affecting Personality Structure," *loc. cit.* XXVI (August, 1932), p. 188.

⁸² Sapir, Edward, *loc. cit.*, 187-188.

⁸³ Cooper, John, "Mental Disease Situations in Certain Cultures," *Journal of Abnormal and Social Psychology*, XXIX (April-June, 1934), 10-17.

⁸⁴ Hallowell, Irving, "Culture and Mental Disorder," *Journal of Abnormal and Social Psychology*, XXIX (April-June, 1934), 1-9.

Willard Waller had assimilated psychoanalytic insights before he wrote *The Old Love and the New*⁸⁵ where he uses the conceptions of identification, repression, projection, trauma, etc. His book on *The Family*⁸⁶ is full of realistic examples of these and other psychoanalytic insights.

Harold Lasswell, doubling in economics and political science, attempted to explain labor and political movements and the motivation of political leadership in psychoanalytic terms.⁸⁷ He further traced organic parallels between the analysis of personality and of "society," and proposed a modification of interview techniques to achieve social diagnosis as well as individual analysis.⁸⁸

Howard Becker with David Bruner utilized a number of psychoanalytic explanations of beliefs and behaviors in bereavement found in ethnographic,⁸⁹ literary, biographic, and case-study materials.⁹⁰

In 1932 in a volume edited by Samuel Schmalhausen, *Our Neurotic Age*,⁹¹ a cluster of essayists, not sociological except in general approach, challenged the world to prove that it isn't cock-eyed,

⁸⁵ (New York: Liveright, 1930).

⁸⁶ (New York: Cordon, 1938).

⁸⁷ Lasswell, Harold, *Psychopathology and Politics* (Chicago: University of Chicago Press, 1930); "Psychoanalyse und Sozialanalyse," *Imago*, XIX (Heft III, 1932), 377-83; "The Psychology of Hitlerism," *Political Quarterly*, IV (1933), 373-84; *World Politics and Personal Insecurity* (New York: McGraw-Hill, 1935); "What Psychiatrists and Political Scientists can Learn from One Another," *Psychiatry*, I (February, 1938), 33-9. The last-named attempts to appraise the status and role of psychiatrist in the stratification of the community and the hierarchy of its value-symbols and practices.

⁸⁸ Lasswell, Harold, "The Triple-Appeal Principle," *American Journal of Sociology*, XXXVII (January, 1931), 523-8, "The Contribution of Freud's Insight Interview to the Social Sciences," *American Journal of Sociology*, XLV (November, 1935), 375-90.

⁸⁹ Becker, Howard, and Bruner, David, "Attitudes toward Death and the Dead," *Mental Hygiene*, XV (October, 1931), 828-37; "Some Aspects of Taboo and Totemism," *Journal of Social Psychology*, III (August, 1932), 337-53; "Tabu und Totemismus . . ." *Kölner Vierteljahrshefte für Soziologie*, XII (Heft I, 1933-34), 52-69. The Freud-Roheim type of interpretation was criticized and a revision suggested: that totemism might arise not from a mythical universal neurotic ambivalence but from the illusions and the influence of psychopathic individuals who were "shamans."

⁹⁰ Becker, Howard, and Bruner, David, "The Sorrow of Bereavement," *Journal of Abnormal Psychology*, XXVII (January, 1933), 391-410. This analysis rested more on Shand's "Laws of Sorrow" than upon psychiatric doctrine.

⁹¹ (New York: Farrar and Rinehart, 1932).

and, as between insanity, genius, sainthood and vice, asked "Who's Crazy Now?" Virtually the same challenge was offered with less emotional flamboyance and more careful seriousness by Trigant Burrow and Lawrence Frank (see above).

Beginning in 1932, Robert Faris entered our field from a new angle. If there be cultural factors in psychoses, it should be possible to demonstrate them by the method of agreement and difference between various ecological and cultural areas. Comparing the residential origins of large numbers of cases committed to psychopathic hospitals, including Negro, Jewish, and small private hospitals, he found a disproportion of schizophrenias and pareses from "disorganized" ecological areas, and of manic-depressives *outside* those areas, with choreas and epilepsies scattered through all class areas.⁹² His thesis was that where social contacts are "adequate," and persons are neither sheltered out from, nor ostracized by, the prevailing culture, schizophrenia is rare, and where it arises, restoration of group acceptance and participation is therapeutic.⁹³ He found that in simple non-literate societies the shut-in or isolate type of personality situation can hardly arise, therefore no schizophrenia.⁹⁴ Faris reiterated this thesis in 1939, in the book he shared with H. Warren Dunham,⁹⁵ and in the discussion thereof.⁹⁶ In the interval there had been corroboration, from two different angles, by Lee M. Brooks.⁹⁷

The amazing mind of Edward Sapir had a range of interests which included social psychology. He shared in the mentioned Symposia on the Unconscious and that of the American Sociological Society. He claimed that one contribution of cultural anthropology is its constant rediscovery of the "normal"—which is valuable to the psychiatrists.⁹⁸ Later he drew attention to the

⁹² Faris, Robert, "Insanity Distribution by Local Areas," *Proceedings of the American Statistical Association*, XXVII (March, 1932), 53-7.

⁹³ "Cultural Isolation and the Schizophrenic Personality," *American Journal of Sociology*, XL (September, 1934), 155-65.

⁹⁴ "Some Observations on the Incidence of Schizophrenia in Primitive Societies," *Journal of Abnormal and Social Psychology*, XXIX (April, 1934), 30-31.

⁹⁵ Faris, R., and Dunham, H. W., *Mental Disorders in Urban Areas* (Chicago: University of Chicago Press, 1939). Cited again below.

⁹⁶ "The Demography of Urban Psychotics . . ." *American Sociological Review*, III (April, 1938), 203-9.

⁹⁷ Brooks, Lee M., "The Relation of Spatial Isolation to Psychosis," *Journal of Abnormal and Social Psychology*, XXVII (January-March, 1933), 375-9.

⁹⁸ Sapir, Edward, "Cultural Anthropology and Psychiatry," *Journal of*

early and increasing recognition by psychiatrists of social components in mental breakdowns.⁹⁹

Maurice Krout is perhaps best known for elaborate classification of minor tics or mannerisms widely observed,¹⁰⁰ to which, in psychoanalytic fashion, he imputed symbolic meanings as symptoms, and which he therefore considered of diagnostic value, whether to psychologists or others. Beginning in 1933, Krout studied the border-field as a clinical-social psychologist. "The Province of Social Psychiatry"¹⁰¹ he conceived as the discovery and control of social causes of abnormal states. With Ross Stagner he made one of the few efforts, thitherto, to test statistically the validity of psychoanalytic theories.¹⁰² Such studies, whether or not they produce "positive results," are an important contribution to psychiatry.

John Dollard's interest in case-study method is naturally associated with an interest in social factors in personal disorganization. He interpreted psychosis as systematized withdrawal from cultural actualities with simultaneous reinterpretation of experience.¹⁰³ One of his papers is a reanalysis of a psychoanalytic case in terms of community life.¹⁰⁴ Like many others he sensed the social causes in mental disease situations, and wrote about them.¹⁰⁵ Dollard's best-known works are *Caste and Class in a Southern Town*,¹⁰⁶ *Frustration and Aggression*,¹⁰⁷ and (with Allison Davis)

Abnormal and Social Psychology, XXVII (October-December, 1932), 229-42.

⁹⁹ "The Contribution of Psychiatry to an Understanding of Behavior in Society," *American Journal of Sociology*, XLII (May, 1937), 862-70.

¹⁰⁰ Krout, Maurice ". . . Obscure Symbolic Muscular Responses of Diagnostic Value in the Study of Normal Subjects," *American Journal of Psychiatry*, XI (July, 1931), 29-71.

¹⁰¹ *Journal of Abnormal and Social Psychology*, XXVIII (July-Sept., 1933), 155-9.

¹⁰² Krout, Maurice, and Stagner, Ross, "A Correlational Study of Personality Development and Structure," *Journal of Abnormal and Social Psychology*, XXXV (July, 1940), 339-55.

¹⁰³ Dollard, John, "The Psychotic Person Seen Culturally," *American Journal of Sociology*, XXXIX (March, 1934), 637-48.

¹⁰⁴ "The Life History in Community Studies," *American Sociological Review*, III (October, 1938), 724-37.

¹⁰⁵ "Mental Hygiene and a Scientific Culture," *International Journal of Ethics*, XLV (July, 1935), 431-9, "Culture, Society, Impulse and Socialization," *American Journal of Sociology*, XLV (July, 1939), 50-63.

¹⁰⁶ (New Haven: Yale University Press, 1937; with other authors).

¹⁰⁷ (London, Oxford University Press, 1939, New Haven: Yale University Press, 1939).

Children of Bondage.¹⁰⁸ Through these books runs a web of psychoanalytic orientations, and in some instances actual Freudian terminology. But Freud is used with discrimination, and the theories are not used as if proved.

J. K. Folsom appears in this sequence at this point because, although familiar with the psychoanalytic approach, he utilized in his 1918 paper, "The Social Psychology of Morality,"¹⁰⁹ almost exclusively the concepts of instinct then current, and applied the theory of sublimation only to the problem of "sins," not to those of mental diseases. In 1931, however, his general text¹¹⁰ contained a chapter on psychoanalytic theories, with critical appraisals, and with a critique of Bain's then recent paper,¹¹¹ accusing him of committing the organismic fallacy; also a chapter on "social psychiatry." In parts of his text on the family¹¹² he fully utilizes, as well as criticizes, psychoanalytic theory. Folsom's theories of the relationships between the two disciplines were well summed up in a paper before the American Sociological Society in 1935.¹¹³

Read Bain's paper referred to above¹¹⁴ does not seem to the writer to commit the group fallacy. It is not "society" which he calls "schizoid," but the majority of our population as persons. He does not personify *the culture*: he merely classifies the evidence of incompatible demands, and of discrepancies between demands, practices, and facilities for realization, in various culture complexes (sex, family, childhood, economics, politics, law, philanthropy, morals, art, medicine, education, science). He points to our personal *and* group efforts to accommodate to cultural confusion as similar in pattern to the compensatory symptoms of individual patients: sadism, masochism; illusions of persecution and of grandeur; paranoid, phobic, and manic patterns; aboulia; regression; fixation; fetishism; overcompensation; rationalization; escape

¹⁰⁸ (Washington: American Council on Education, 1940), esp. pp. 8-10.

¹⁰⁹ *American Journal of Sociology*, XXIII (January, 1918), 433-490.

¹¹⁰ *Social Psychology* (New York: Harper, 1931), 167-221, 604-650.

¹¹¹ Bain, Read, "Our Schizoid Culture," *Sociology and Social Research*, XIX (January-February, 1935), 266-76.

¹¹² Folsom, J. K. *The Family, Its Sociology and Social Psychiatry* (New York: Wiley, 1934), *passim*.

¹¹³ Folsom, J. K., "Sociology and Psychoanalysis," *American Sociological Review*, I (April, 1935), 216-20.

¹¹⁴ Bain, Read, *op. cit.* Cf. also "Adolescence: Psychosis or Social Adjustment?" an indictment by the educational sociologist Harvey Zorbaugh "of our pattern of civilization, which makes adolescence a major crisis of social adjustment." *Journal of Educational Sociology*, VIII (February, 1935), 371-7.

mechanisms; fantasy-thinking. He speculates as to whether unreason and chaos will supervene, or whether we will have a new and consistent culture based on social scientific insights.

In the following year Bain presented a critique of psychoanalytic theory: ¹¹⁵ he found it mechanistic, dualistic (mind *versus* body), based on an outmoded instinct hypothesis, color-blind to cultural factors, and fuzzy in its definitions. That he continued to find its concepts and insights useful is evident in his "Cultural Integration and Social Conflict," ¹¹⁶ where he again traces personal conflicts to cultural inconsistencies as causes. He notes the results when similar personalities are simultaneously affected by the discrepancies and inconsistencies of modern western cultures, viz.: competition and conflict of attitude within persons, between incompatible motives endorsed by the competing culture patterns. Then, behaviors of schizoid quality become noticeable. In this respect the essay extends the sort of socioanalysis found in Miller's "The Oppression Psychosis." ¹¹⁷

Harvey W. Zorbaugh, writing as an educational sociologist, raised about adolescents the same kind of questions that have been raised about geniuses and criminals: Are such people mentally pathological? ¹¹⁸ It is partly a matter of who is diagnosing and how the culture treats them. Our pattern of civilization makes adolescence a major crisis of social adjustment.

In "Mental Hygiene and the Class Structure" ¹¹⁹ Kingsley Davis impugned the objectivity of psychiatrists' own norms, tracing their axioms and criteria of therapy and sanity to norms absorbed from the ethos of Protestant Culture: a salutary application of the sociology of knowledge to the sociology of a profession. He has not notably utilized psychoanalytic interpretations. ¹²⁰

The ecological study of mental diseases begun by Robert Faris in 1932 ¹²¹ was not followed up until H. Warren Dunham pub-

¹¹⁵ Bain, Read, "Sociology and Psychoanalysis," *American Sociological Review*, I (April, 1936), 203-16.

¹¹⁶ *American Journal of Sociology*, XLIV (January, March, 1939), 499-509, 724-5.

¹¹⁷ *Op. cit.*

¹¹⁸ *Op. cit.*

¹¹⁹ *Psychiatry*, I (February, 1938), 55-65 (No. 37 in this volume).

¹²⁰ E.g. "The Sociology of Parent-Child Conflict," *American Sociological Review*, V (August, 1940), 523-35.

¹²¹ See above.

lished further studies in the Chicago area in 1937-1940,¹²² based upon all admissions to four State Hospitals, 1922-1934. Schizophrenes and manic-depressives were mapped and ratios were based upon populations over 15 years of age in subcommunities. Schizophrenes came chiefly from slums, manic-depressives from upper levels, confirming Faris' findings. The two published jointly in 1939 *Mental Disorders in Urban Areas*¹²³ based on 34,864 cases. Rates (except the manic-depressives) decrease steadily from 362 in slum districts to 55.4 in "residential" areas. Catatonias tended to come from the foreign-born and Negro groups (in poverty). Paranoias and hebephrenias tended to come from rooming-house areas (isolated from normal primary-group relationships). Alcoholisms and drug addictions came from "zones of transition" and poverty. General paralyses came from "Hobohemia" (male and poverty-stricken). Senile dementias were scattered, but there was some clustering in the crowded slum and Negro areas where there were no facilities for their care.¹²⁴ The Chicago findings were confirmed by data from Providence, Rhode Island.

Herbert Blumer's name is not ordinarily associated with our field, but in 1937 he spotted the theoretical shortcomings of those who attempted to derive all societal disfunction from disorganization on the personal level, and claimed that just *how* social disorganization results in personal disorganization had not been charted or proved.¹²⁵ In 1939 the psychiatrist, Gregory Zilboorg, defended Freud from criticisms of the sociologists, pointing to his recog-

¹²² "The Ecology of the Functional Psychoses in Chicago," *American Sociological Review*, II (August, 1937), 238-49; "Ecological Studies of Mental Disorders," *Mental Hygiene*, XXIV (April, 1940), 238-49. The former of these two was criticized by Maurice Krout: *American Sociological Review*, III (April, 1938), 209-212. Stuart A. Queen also presented an appraisal and further data: "The Ecological Study of Mental Disorders," *American Journal of Sociology*, V (April, 1940), 201-209.

¹²³ *Op. cit.*

¹²⁴ This reminds one of Hollingshead's recent studies showing that adequate outpatient care of mental patients by psychiatrists is largely a function of their professional bias toward intensive therapy for only educated and middle-class patients. Slum patients get institutionalized more readily, just as slum juvenile delinquents get caught and committed more frequently, for good or evil.

¹²⁵ Blumer, H., "Social Disorganization and Individual Disorganization," *American Journal of Sociology*, XLII (May, 1937), 871-7. In his recent terminology he might admit that psychoanalytic theory provides useful "sensitizing concepts."

nition of social causes and social outlets for repressed affect.¹²⁶

James W. Woodard, working both in psychology and sociology and as a lay analyst, undertook direct psychoanalytic methods to explore social motivation. Two of his papers may be taken as among the attempts at a partial answer, not to Blumer, but to the challenge he posed. In "The Relation of Personality Structure to the Structure of Culture"¹²⁷ he identified Freud's "super-ego" with the structure of culture as internalized, and (like Lasswell, not to mention Plato) sees a sort of organismic analogy between "id, ego, and super-ego" and the social class structure. He also advanced, however, certain criticisms of the "social" theories of Freud, Horney, etc.

Mandel Sherman compared the ideational and imaginal (i.e., cultural) content of illusions, etc., in psychotic patients of different racial or cultural groups. Racial differences were attributable to differences of milieu. His book, *Mental Conflicts and Personality*¹²⁸ stresses social-environmental factors in mental conflict, and the constructive possibilities in mental conflicts.

Harriet Mowrer criticized the psychiatric studies of alcoholism conceived as *in se* psychopathic and interpreted psychoanalytically. She compared a group of 25 married alcoholics with a group in which the common element was illness as an escape or attention-getter, and with a second group composed of "normals." She concluded that alcoholics have a socially (rather than mentally) maladjusted personality pattern, including the use of alcohol to achieve the focus of attention craved since childhood.¹²⁹

Ernest W. Burgess did not contribute specifically to our border-field until the symposium on Freud's contributions in 1939.¹³⁰ At that time he reviewed some of the same material cited here—noting a period of resistance from 1909 to 1919, and thereafter an increasing discovery and utilization of Freud's ideas by sociologists and other social scientists. Burgess' explanation of their slow acceptance is in terms of a critique of Freudian ideas and methods

¹²⁶ Zilboorg, G., "Sociology and the Psychoanalytic Method," *American Journal of Sociology*, XLV (November, 1939), 341-55.

¹²⁷ Woodard, James W., *American Sociological Review*, III (October, 1938), 637-51.

¹²⁸ (New York: Longmans, 1938).

¹²⁹ Mowrer, Harriet R., "A Psychocultural Analysis of the Alcoholic," *American Sociological Review*, V (August, 1940), 546-557.

¹³⁰ "The Influence of Sigmund Freud upon Sociology in the United States," *American Journal of Sociology*, XLV (November, 1939), 356-74.

which is itself a valuable contribution to the psychoanalysts, if they will read it.

That our report closes at this point is an accident of dates. Several of the writers cited in the foregoing account have continued to contribute to the give-and/or-take between the disciplines, since 1940. The present review has stopped arbitrarily at that date because the absorption of psychoanalytic ideas by the wider public, and even by sociologists, was by then so general that their use became commonplace. Writers since then either take them for granted or cite them to their original sources, or test them by logic and by modern field research techniques, and/or attempt to modify them in the light of facts. Few of them trouble to cite the pioneers who bridged the gap between the two disciplines.

An interesting piece of field research in this field of interdisciplinary interaction would test the extent and nature of actual intellectual interchange: Comparable lists of books, articles, names, and topics in psychiatric social psychology and in social psychiatry or psychoanalysis could be submitted to comparable lists of sociologists and of psychiatrists, to measure roughly how much of all the interactive thinking and effort described above has really permeated; and whether the bulk of psychiatrists yet have any knowledge of the ideas, let alone of the literature, that we have been discussing.

THREE

Social Psychiatry

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THERE is the story about two psychiatrists, man and wife, whose boy was once asked by a friend, "What do you want to be when you grow up?" He replied unhesitatingly, "A patient." Apparently what he meant was that he wanted to be the kind of person who was absorbingly interesting to his parents. The overtones of this anecdote are suggestive.

Psychiatry has been until recently a conventional branch of medicine dealing with the study and treatment of disorders of the human organism, its behavior, attitudes and cognitive processes whenever emotional conflicts appeared. Like its parent, medicine, psychiatry eventually assumed a three-fold task: (1) *objective research* in which the scientist sought to discover typical conditions under which patients became neurotic or psychotic, and a satisfactory classification for the modes of disturbance; (2) *therapy*, in which by clinical practice and experiment the practitioner tried to formulate methods of treatment specially adapted for cases in the various diagnostic categories; (3) *prevention*, in which the physician cooperated with community agencies to alter dysgenic conditions related to an increased incidence of mental disorders. The first of these was similar to pure science, while the other two were more an applied science or technology in which the mental hygiene movement, public health, clinical psychology and social work were indispensable allies.

As psychiatry matured, it became obvious that each of these areas had unique social dimensions. For example, Dr. Jurgen Ruesch and Professor Gregory Bateson, in a new inter-disciplinary study, declare that American patients are typically anxious about being *different* from others, while European patients worry because they are too much *like* other people. Hence a therapist will encourage

* From *The Antioch Review*, XIII (Spring, 1953), 67-85. Reprinted by permission of the author and the publisher.

his American patient to work through and accept his difference; when it no longer threatens him, he can then assume his place in the group. In Europe, however, the therapist will help the patient accept his similarities with others and only after this acceptance can he work out his own unique style of life.

Whether this is an absolute difference in the two cultures may be doubtful; but the example shows clearly that different societies have unique conflict situations so that the conditions for neurosis and psychosis are functions of social patterns. Anthropology, social psychology, and sociology are becoming increasingly contextual in their analysis, i.e., they explore the meaning of behavior in the context of social expectations to which the person responds. In like vein psychiatry is enlarging its task to include the social atmosphere of the patient, his relations with family, neighborhood, friends, occupational conditions, institutions, social controls or ideologies—in fact anything which may have played a vital role in his socialization. A few brief illustrations may point this up more vividly.²⁸

SOCIAL AND CULTURAL DIMENSIONS OF MENTAL DISORDER

A British psychiatrist, Dr. Carothers, has made a study of neuroses and psychoses in Kenya colony in which nine-tenths of the population live at home on reservations participating in the traditional preliterate culture. The other tenth work as laborers in cities or on plantations owned by Europeans and are known as the "detribalized." Half the first admissions to the mental hospital at Nairobi come from the detribalized one-tenth of the population, while the other half are from the other nine-tenths who live at home. The incidence of mental illness for males is nearly twice that for females, since it is the men who form the bulk of the laborers. While schizophrenia in Kenya shows a rate comparable to that of Europe and America, Carothers asserts that there are no cases of cerebral arteriosclerosis at Nairobi. He believes that this is a disease of civilization connected with competitive struggle; in general, he says, arteriosclerotics do not play, pursue their ends doggedly, and are always living under pressure. This is foreign to the African mode of life. Other psychoses show a much lower rate in Kenya than in Euroamerica.

Elsewhere Carothers observes that there are no cases of obses-

sive compulsives or anxiety neurotics at Mathari hospital. This, too, is significant, for as another British psychiatrist, Dr. Halliday, has pointed out, the increase in obsessives in Western culture is related to repressive child-rearing methods during the explorative period of infancy (from about six months to the third year of life). In Kenya there has been an increase of mental disorders among the detribalized but the rate is still very low: about 3.4 per 100,000 of the population per annum; while in England and Wales the corresponding rate was 57 per 100,000 and in Massachusetts between 72 and 86. Carothers declares that the rarity of psychoses among preliterates is "due to the absence of problems in the social, sexual, and economic spheres" as compared with the frequency of these issues in Euroamerican society. It is also incidentally a fairly good proof that the indigenous peoples of Kenya have little chance to participate in the competitive culture of dominant whites. It is worth observing that this exclusion therefore seems to prevent a sudden rise in mental disorders. Nationalism and industrial progress demanded by the Africans may eventually bring unanticipated results in higher incidence of neurosis and psychosis. What price civilization?

This is not to say that mental disturbances are unknown among nonliterate peoples. J. M. Cooper reports that eighty-five per cent of the Crees are hysterical; Fortune's description of the Dobuans shows that what we would call paranoid conditions are culturally dominant. Other simple societies regard the deviant as especially holy. Research on these cultures does not yet permit many solid generalizations, although it seems likely that, on the whole, they display less neuroticism than civilized peoples. Freud's hypothesis that civilization is accompanied by increased neurosis seems likely as a statement of fact. But Freud's explanation would probably be rejected by social scientists today. They would not agree that preliterates have *less* repression of original drives; frequently they seem to have more. Far more crucial is their cultural consensus on types and modes of control. With little room for alternatives, a tribal member can accept and internalize controls and feel comfortable about it; if he suffers, all suffer alike.

On the other hand, the view that social complexity, in and by itself, is the chief cause of mental disorders, may be plausible but does not stand close analysis. It is like saying that a hot climate is the cause of bacterial diseases. Of course the bacteria thrive in the heat. Yet high temperatures cannot bring about malaria or

bubonic plague. Karen Horney and Read Bain advance the analysis further by asserting that it is not the *number* of demands made on the individual in society, but the *incompatible nature* of the demands that increase emotional disturbances. Thus we have religious benevolence vs. hard competitiveness, passive obedience to parents vs. aggressiveness toward others, stimulation of needs vs. actual frustrations in attaining them. This is a more convincing thesis because it deals in specifics and not in purely general factors. Yet as Ralph Linton remarks, every culture has its inconsistencies, and one of the tasks of living is learning how to deal with them. Is it more a sign of mental health to be disturbed by the inconsistencies than to accept them? We do not pretend to answer the question. But the social scientist wants more than a plausible hypothesis like cultural conflict. He must know precisely how it operates and how it is transformed into modes of behavior restricting the field of choice or resulting in personality distortions.

He therefore showed considerable interest when Dr. Halliday brought out his provocative volume *Psychosocial Medicine* in 1948. This book presents the thesis that cultural change in the last seventy-five years has resulted in an improvement in physical health but a decline of mental health if measured by the incidence of psychosomatic disorders. The general death rate, the infant mortality rate, the proportion of stunted children, the rates for tuberculosis, for typhoid and rheumatic fever and the incidence of rickets all declined. But the indices for psychosomatic illness had a corresponding increase: the rates for non-arthritis rheumatism, gastritis, peptic ulcer, exophthalmic goiter, diabetes and the cardiovascular hypertensive disorders. How can this be explained?

Halliday advances the view that the atmosphere of infancy in the 1870's was physiologically bad by present health standards; dirt was plentiful, pure water absent, there was little or no sanitation, much overcrowding and long working hours. Psychologically, however, the period had much to commend it. Breast feeding was practically universal, there was prolonged bodily contact between child and mother, sphincter training did not occur until the second or third year (infantile excretion worried that generation little because it was accustomed to fecal odors). Floors were stone or bare boards and there was little furniture or bric-a-brac to serve as forbidden territory. Any toddler could explore the house without destroying "nice things." Families were large and playmates numerous.

In the twentieth century, on the other hand, the physiological environment was cleaner, more hygienic and free of germs, with better nutrition and all-around care. Yet psychologically it deteriorated. Breast feeding declined, the infant was placed on a chronological schedule violating bodily rhythms, body contact between mother and child was reduced, baby carriages and playpens isolated the child. When the child cried, the mother left him alone lest she spoil him, and bowel training began early, even before six months in some cases. "When the clock struck certain little pots were punctually applied to little bottoms." Furnishings in the home increased: carpets, vases, ornaments and breakables of all sorts. The ideal of having a nice looking home conflicted with the child's exploratory activities—and the child lost. Families became smaller and chances for play with siblings at home decreased. At the same time intimate relations with parents became intensified, increasing both dependence and hostility. Arnold Green has named this "personality absorption."

This hypothesis is very suggestive; but like most research in this field, there is a plethora of problems relating to definition of terms, availability and comparability of data, and uncontrolled variables.

For example, the social changes mentioned by Halliday may be primarily characteristic of the middle classes (not of farmers and industrial workers). Furthermore, Halliday measures in terms of psychosomatic disorders, rather than in terms of psychoses and neuroses. Adequate parallel statistics for the United States are lacking.

To support Halliday's hypothesis, we should find an increase in all forms of mental disorder in this and in European countries. But again the evidence is lacking. Indeed, Goldhamer and Marshall come to a contrary conclusion, stating that there has been no long-term increase during the last century *in the incidence of psychoses in early and middle life*. Here questions also arise, however, since using Massachusetts data they are dealing with an urban state; and the urban incidence of psychosis is higher than the rural. Furthermore, Massachusetts has had more adequate hospitalization than most states during the past century.

It might seem that Halliday's contention would be supported by draft statistics on psychiatric rejections—one out of fifty in World War I and one out of seven in World War II. Unfortunately, dif-

ferences in screening methods and criteria invalidate any deductions.

Compounding research problems, the apparent increase in psychoses indicated by statistics (186.2 per 100,000 in 1903 and 382.4 in 1946) may be more apparent than real. Deutsch suggests that: (1) with more facilities there's an increased tendency to hospitalize patients; (2) people are better educated today in mental health concepts and are more willing to commit relatives; (3) higher standards of care result in patients staying longer; and (4) greater life expectancy has increased the number of older patients.

An early study by Faris and Dunham, *Mental Disorders in Urban Areas* (1939), revealed that schizophrenia commitments from Chicago tended to follow an areal pattern with the highest incidence near the center of the city, declining gradually toward the outskirts. With manic depressives, high and low rates were irregularly distributed throughout the city. Educational levels of manic-depressives were higher and there seemed to be some tendency for them to come from higher rental areas. Both manic and depressed types had larger numbers of married than of single for both sexes; while all three types of schizophrenia had more single than married men, but more married than single women. It was also significant that the schizophrenia rate was considerably higher for those races residing in areas not primarily populated by members of their own groups.

Thus the Faris and Dunham study revealed suggestive correlations between types of areas and the incidence of psychosis. But Miss Owen showed, in 1941, that various areas also affected the commitment rates themselves. She points out that "the kind of behavior which would be indefinitely tolerated in an area of social isolation could well be thought insane in an area of family dwelling and neighborhood participation." In short, the visibility of a psychotic would be heightened in some cases and lowered in others.

Such studies suggest the importance of class factors in personality adjustment, although research is still inconclusive on this point. Dr. Ruesch believes that lower-class groups are characterized by conduct disorders; the middle class by psychosomatic disorders associated with repression; and the upper-class by psychoneurosis and manic-depressive psychosis. This clearly does not jibe with the high incidence of schizophrenia in lower-class areas revealed in

the Faris-Dunham study. Ruesch is on firmer ground when he shows that psychosomatic conditions are more prevalent among social climbers and alcoholism among the social decliners.

Lantz's study of 1,000 psychiatrically diagnosed cases in the Air Force sheds some light on the relationship between class status and mental disorder. He shows that 51.4 per cent of those with poor parents had severe psychoneurosis, but only 36 per cent and 39.5 per cent of those whose parents were "average" and well-to-do respectively. The same tendency appeared in psychotics and psychopaths where 10.2 per cent of the poor were psychotic, 4.3 per cent of the "average," and 1.9 per cent of the well-to-do. This close correlation between income and personality disturbance points up the need for more research on the development of neuroses and psychoses in the lower-income population.

This research phase of psychiatry has a logical if not a temporal priority over therapy and prevention; and we have made only the barest beginning in this important area.

THERAPY AS A SOCIAL RELATIONSHIP

The social scientist has already increasingly emphasized the notion of role as the key concept for understanding personality. The role consists of a typical pattern of responses to regular social expectations; in the process of building up a role, the person internalizes the attitudes of others and directs his behavior accordingly. Role change is at a maximum in early childhood when the individual is trying out various combinations with parents and siblings; and in adolescence when numerous possibilities for adulthood open up. We cannot analyze his roles by focussing on the individual apart from his social field; but only in terms of interaction in that field. As Sullivan so well put it, "The self is composed of reflected appraisals." In fact, Sullivan defines psychiatry as "the study of interpersonal situations," a statement almost exactly identical with a commonly used definition of sociology. To the extent that sociology studies deviant individuals, its field is precisely the same as that of psychiatry, though the training of the researcher is different.

Without discussing how the deviant role is established at the moment, we observe that in therapy, an attempt is made to alter that role. This is done by setting up a special social system which we may call the therapeutic situation. When compared with the

everyday interactive relations of the patient, the situation shows three marked differences. First, it is permissive, allowing, as Professor Parsons has pointed out, both the expression of positive transference and of hostility without incurring the customary responsibilities of such acts, or threats of reprisal. Secondly, there are specially defined and impersonal limits to the situation—e.g., specified appointment times and a careful separation of the social life of the patient and therapist and with no overlapping. Finally, this situation involves novel definitions both of sickness and treatment. The ordering and prohibiting of the physician is modified as the therapist acts as a psychological midwife, encouraging the patient to seek out his own ills and problems; then helping the patient to bring to birth a new role that is itself the "cure." Mutuality creates the remedy.

This description of the therapeutic situation has taken its model from treatment in an office where only a pair relationship is involved. Similar principles apply to other forms of therapy, but there are many changes of detail. For instance, experimentation with disturbed children, military personnel, adolescent and parental groups has shown that the therapeutic situation may include a number of individuals. Group therapy is coming into its own: the names of Slavson, Schilder, Peres, Coffey and others indicate an increasing awareness of how the group can be utilized for role alteration. One illustration will suffice to point out similarities and differences between group therapy and the classical pair relationship.

Hubert Coffey, reporting on a group therapy project at Berkeley, California, outlines three chronological phases of the process. The first is one of defensiveness and resistance. The leader asks members of the group to state their problems as clearly as they can; many of these fall into well-defined categories. But the description of their own traits and behavior (the conscious social role) soon appears to be different from the actual behavior (as observed by others in the group) which is the defensive, unconscious social role whose techniques have proved unrewarding in the past. With the aid of the group leader or therapist, each person gradually shifts attention from the *content* of his conversation to his *role* in the group. The group leader first aids the person himself to interpret these regular patterns; then asks members of the group to comment on them. By this time, most of the neurotic role has come out into the open and the therapist himself needs to fill in only

partial detail. Members of the group do the rest. Though they do not use technical language, their perceptions are keen and they do most of the interpreting. This again emphasizes the permissiveness of the situation and the mutuality of the search.

The second phase of the process is called the period of confiding. Here the problem for each member is, "Why is this role necessary for you?" The leader and the group now place special emphasis on the why and the whence, so all of them together seek out reasons for the development of the role—parental relations, early memories, dreams, fantasies, sibling problems and other genetic factors come to the fore. As each person brings up such data, the leader encourages the members to contribute their hunches and associations about the memories of others as well as themselves. Eventually the confiding period unifies the group and makes it a social unit with a common goal. The several strangers come to recognize their common problems, to see beyond defensive roles, and to accept idiosyncrasies. Since each person experiences acceptance by the group regardless of his problem, he gains new and unexpected support in redefining his difficulties and begins to develop a new self-confidence.

In the third period or the integrative-prospective stage, the dominant question is, "Where do you go from here?" After gaining new confidence and social support from the group, each person begins to work out a change of role and slowly drops the social defenses that obstructed his development before. He begins to extend this new role to other social situations which, by this time, no longer seem quite so threatening. Members of the group discuss ways and means of achieving life goals in more realistic terms, then try them out in their daily living, reporting successes and failures to the group. Significant and worthwhile changes occurred for most of the members.

Not only is group experience a potent reinforcement for *patients*, but its importance for *therapists* is becoming more and more evident. Especially in the child guidance clinic, the therapeutic team has discovered new ways of increasing insight and providing for more concerted effort in altering the role of the individual.

Mental hospitals constitute a still different social system for therapy. We are not speaking here of purely custodial institutions whose chief aim is to dispose of patients and keep them out of circulation. Custodial care is only "protective incarceration" as Dr. Cameron pungently observes. Therapeutic hospitalization is

another matter; it is becoming more and more aware of the social functions it must perform. The hand of tradition, however, is heavy in the state mental hospitals; and their social system, organized originally for protective incarceration, shifts only slowly and unsteadily toward a more socialized therapy.

Barrabee's unpublished sociological study of a mental hospital will furnish a few brief observations of the social relations pertaining to therapy in the institutional setting. First of all, the patient has a new environment in which many former interactive processes have disappeared. Most of the property is publicly owned; there are no sexual relationships, no family ties, no work for money, no need to support others or oneself. Prestige does not depend on wealth or family connection or vocational achievement. Instead of devoting the major portion of his time to vocation and family, he now gives most of it to fellow-patients, somewhat less to the attendants, still less to the nurses and even more reduced amounts to doctors, occupational therapists, psychologists, social workers, and other staff members. His connection with the hospital culture is chiefly a function of his contacts with the attendant. For the average patient, the attendant is the hospital, or at least symbolizes its values.

From the standpoint of staff, however, the attendant *least* represents hospital values. In the hierarchy of administration he is clearly at the bottom, with the doctors and superintendent at the top. In between come nurses, social workers, psychologists and occupational therapists, whose place in the hierarchy varies with each institution. The bureaucratic structure of the system requires that there be a chain of command; therapy, on the other hand, implies that there be cooperative teamwork with functional differences emphasized and authoritarian elements played down. The role of a physician in the mental hospital involves many administrative elements that do not appear when he has nothing but office calls. In the institution he makes daily decisions involving government, social psychology, sociology and education. He is a social therapist *malgré lui*. Insofar as he is unaware of what is happening, he resists the acceptance of, or even the recognition of, the sociological dynamics of therapy. He may utterly fail to see that permissiveness for patients implies permissiveness in the bureaucratic relationship as well. Anxious authority can be more detrimental to hospital atmosphere than anxious patients. Sociological therapy is simply an extension of group therapy and therapeutic team treatment to the

institutional situation, utilized to create an atmosphere that will loosen pathological defenses of the patients. This kind of a job means periodic consultation on a give-and-take basis; it may put the doctor in a position where he is responsible for the patient's entire day. To handle this, he must know more about the patient's social relationships and how to use them—something he never learned in medical school. Likewise the staff members who never considered themselves to be therapists must accept a share of responsibility to which they are unaccustomed. With therapy a function of group processes, free collaboration is the price to be paid for it. At the same time it calls for a flexibility of role that challenges traditional methods for training medical personnel.

The role of the nurse in the mental hospital also differs considerably from, say, her role in the general hospital. In the latter she deals with each patient as a specific case, but in the mental institution she nurses a group of patients together on the ward and has to consider their relationship with each other. Many of the problems involved are not covered by standard nursing procedure. With the coming of the sociological emphasis, the nurse has to take a more active part in the social concerns of the ward and not simply carry out orders. This shift in role may create such anxiety that she retreats to the bureaucratic haven again; or it provokes the anxiety of the supervisor who feels her authority threatened.

It would be rewarding to discuss these status roles and their interaction in the hospital at greater length, but the main point is clear. This shift toward new forms of therapy with its emphasis on flexibility of role and actual practice of mental health principles puts great strain on hospital personnel. It means a resolute attempt to destroy the narrow conception of role where a specialist is "a man who is down on what he's not up on," and to regard all specialists as functional members of a working team where each may play alternately a leading, then a subordinate role. The very closeness and intimacy of increased collaboration bring all personnel face to face with the necessity of learning the realities of group dynamics, not as a mere theory but as living practice.

PREVENTION AS A SOCIAL TASK

In a sense, prevention of mental disorders is everybody's job, not merely a task for the experts. Social control is impossible unless public interest is mobilized in the family, school, church, industry

and business. But there are dangers in allowing the problem to be captured by popular crusades with their claims for a panacea. Science must be at the center as in the public health movement which, as Kingsley Davis says, "intends not so much to make everybody bouncingly robust as to prevent the onset and spread of definite diseases." Thus while there may be a partial convergence of aims with the mental health movement, it would be a mistake to allow this identity to become absolute. As Davis shows only too well, mental hygienists often make mental health into a moral ideal of integration and harmony, an individual ability to become a blend of good conformist and successful competitor. They take for granted private initiative, personal achievement, and competitive ability as a part of "normal" functioning—thereby presupposing the social order which demands these values. "Normality" becomes a middle-class ethic disguised as a supposedly scientific demand.

The realities of the class system are therefore frequently disregarded by mental hygienists. Have they any philosophy for the lower-income groups? Or are they trying to superimpose the middle-class ethic upon those who, because of restricted demands of their environment, cannot inhibit aggression or become polite competitors without losing prestige among their peers? To force middle-class decorum and restraint upon such persons would be to increase the burden of guilt which mental hygienists say they are trying to remove. Prevention must operate in the social context and thus take into account the relativity of the causal nexus. When the social scientist collaborates with psychiatry, one of his chief functions is to keep this pluralism of social perspectives in the forefront of the picture.

On the purely somatic basis, much can be done to prevent mental illness. New discoveries for the treatment of syphilis will probably result in greatly reducing the incidence of paresis which accounts for about ten per cent of state hospital admissions. Improved treatment for encephalitis can help to eliminate the Parkinsonian syndrome that often follows from it; increased control of tuberculosis through the newly discovered forms of immunization will decrease the incidence of secondary emotional involvement frequently accompanying it; the same is true for poliomyelitis.

The main task of prevention, however, extends far beyond this into the social field where distortion of interpersonal relations occurs, and where there are no physiological structural defects. It is

important, as it is for cancer, to detect neurosis, psychosomatic illness, and the pre-psychotic states in early stages so that prompt therapy can stop the spread of systematized distortions in response patterns, in organic symptoms, or in delusional structures.

This is the Achilles heel of preventive measures today. Communities have no planned program of detection; where treatment is available, patients can only obtain it if they are in advanced stages of their maladjustment. Can the detection be done by mental health clinics? The Division of Mental Hygiene of the United States Public Health Service reported only 333 of these clinics in 1950 for a population of over a hundred and fifty million people. Here and there an entire state will have only a single clinic. Is the detection to be done by the psychiatrists? Rennie and Woodward estimated in 1948 that the United States had only 3,200 of these and needed, on a conservative estimate, at least 10,000 more. It is painfully evident, moreover, that these specialists are available only as a last resort, not for early diagnosis. Can detection occur in the schools? One estimate is that five per cent of the children in the elementary grades need early treatment at any one time; experts claim that a clinic team of one psychiatrist, two psychologists, and two or three psychiatric social workers are needed for every 40,000 school children. Yet only in the larger cities are school authorities even taking steps in this direction; and nowhere, so far as I am aware, has this standard been achieved. In 1943-44, only 266 cities had visiting teacher or school social worker programs. A prime need, of course, is the training of teachers to help diagnose in the early stages. Yet in one school of education the curriculum provided for one course in which prospective teachers were taught both principles of diagnosis and therapy for all mental cases in a single semester! Even supposing that teachers became better detectors than they now are—where would they send their cases? Not only teachers but pastors, rabbis, recreation leaders, personnel managers and many others report that they cannot find treatment available for people who need it at the price they can afford to pay. One after another they complain that if a person is not critically ill, he gets no help whatever, at least of a professional nature. If early treatment is the touchstone of prevention, we must face the uncomfortable fact that we lack even the rudimentary facilities for this obvious and necessary first step.

Since the family is the matrix for so many emotional conflicts,

all agree on the need for increased enlightenment on child-rearing methods to encourage confidence, adequacy and mutuality. But family life education has barely scratched the surface. Few families are aware of how everyday habits, chosen for convenience, can subtly change into ways of distorting young personalities. Even more serious is the fact that the family is practically unreachable by ordinary community programs, being a private enclave encouraged by our prevalent individualism. Indeed, as a matter of social policy, isn't this very privacy a necessary adjunct to independence of thought and action which we regard as indispensable to democracy? To wish for a common life that absorbs family uniqueness is to do violence to a part of our cultural heritage. Realistically, then, we are forced to recognize that our approach to family life must be indirect. Strategy requires that our advance be made through agencies and institutions intimately related to family living. We mention only three as deserving special mention: school, church, and medical care.

Diagnostically, the school can do much with the aid of behavior specialists like psychologists, visiting teachers, counselors or psychiatrists. Such leaders, by organizing discussion groups of teachers and parents, can increase sensitivity to typical symptoms like truancy, sudden drop in grades, increased withdrawal, failure to participate, overaggressiveness, or warding off others because of expected unkindness. A special program then calls for reporting such problem cases to the key leader, who then arranges conferences with teacher, parents, principal, attendance officer or guidance personnel. This results in a mutual treatment process. The family becomes part of a collaborative team. The parent becomes convinced that he is not alone in dealing with his child's behavior problems; this is reassuring when he is so often blamed or shamed without guidance, if not given peremptory advice. The teacher enjoys the same kind of re-enforcement too. Even a modest program like this will gradually send out its influence to other families who begin to join in a wider community effort. To the degree that parents and friends observe effective results, they will tell others and enlarge the circle of cooperators.

In church or synagogue, the religious leader has a great natural advantage in observing the daily life of his communicants. He has intimate relations with families on such occasions as birth, death, marriage and sickness. The longer his residence in the community,

the greater his opportunity to see the process of family relations at close range. He may not even need the case history approach if he has done his job.

His theological or doctrinal beliefs may benefit his work with the congregation; or they may obstruct what he does in the mental health field. In general, religious workers have one of two attitudes toward the problem. They may believe that a thoroughgoing religious commitment solves all problems. In this view, psychiatric help touches only a superficial level of the personality. Or they may accept a division of labor in which the therapist deals with problems requiring skilled attention at the secular level. From this point of view the religious task is no longer primary; but the religious orientation will crown and complete the achievement of personal integration at the secular level.

The task of promoting mental health requires the second viewpoint rather than the first. A priest, minister or rabbi with the first point of view can wreck a cooperative program, either because he misunderstands the aims, or because he is hostile to those who appear to compete with him, who make uncomfortable demands, or who appear to be dealing with trivial affairs in view of what he regards as a more ultimate and final commitment. If it is true, in Bettelheim's phrase, that for unraveling emotional difficulties, "love is not enough," so the religious leader, to be of service here, must recognize that "religion is not enough" either. Skill is the prime necessity.

Assuming, then, that the religious leader has no anxiety about cooperation with a therapeutic program, he has countless opportunities for detecting family conditions creating neurotic patterns. His constant home visits give chances for expressing attitudes toward family discipline, sibling relations, educational trends and emergency reactions. He can express these attitudes subtly rather than dogmatically, making the visits a contribution to family morale. If properly trained, he can also detect maladjustments in early stages and be available for counsel or smooth the path of referral to skilled workers in mental health. His people will often accept these suggestions when they would not listen to a friend or relative.

Perhaps as important as either of the above is the family doctor. In spite of increasing specialization in medicine, the vast majority of physicians still have continuity of practice with individual families. Many authorities are agreed that persons with psychological

problems are more often observed in the early stages by a doctor than by a psychiatrist. The general practitioner has the added advantage that the disturbed person will be even more likely to confide in his physician than in his religious guide; the patient is less likely to conceal his problems in the presence of one who can give him specific, physical relief.

The physician, too, realizes (and often declares openly) that from fifty to eighty-five per cent of his cases are not primarily organic in origin. The percentage will depend on his awareness or philosophy. Authorities put the number of psychosomatic illnesses at about one-third of the total number of medical cases, with another third having emotional involvements that intensify organic complaints. The usefulness of the practitioner in detecting psychiatric problems depends on the adequacy of his training or his ability to learn from experience about emotional disturbances in his patients. If he lacks sophistication about interpersonal problems, becomes impatient, or shows reluctance to pursue the complexities of diagnosis, he will take the easy way out—give many placebos, assert that “there is nothing wrong with you,” “your trouble is in your mind,” “you need a good rest,” or “you must have another operation.” Coupled with this, the physician may show active hostility toward psychiatrists. Sometimes this arises from ignorance or jealousy, but at other times it is the fruit of too much knowledge—bitter knowledge about individual psychiatrists who have failed to help patients referred to them; or knowledge that their patient cannot afford psychiatric treatment.

Consequently, in the medical field, as in the religious, aid for a mental health program can come only from those whose philosophy is free from professional jealousy, whose psychiatric training is more than perfunctory, and whose knowledge and use of community resources is informed and cooperative. Given these requirements the physician is in a key spot. He can not only diagnose early disturbances but can give supportive treatment or help relieve symptoms by encouraging quick ventillation of tensions. He can discover family relations that perpetuate anxious or confused trends and suggest ways of behavior that turn the tide toward mental health. His care for the child, beginning as it does with birth, is often continuous through life, offering unobtrusive but effective guidance. Simultaneously he has charge of the adults in the same families and can help regulate reciprocal relations for mutual cooperation. Even short acquaintance shows him where the

fulcrum of each family is and where he can apply his methods most effectively. When problems become too unmanageable he will know precisely where to get the community service needed: perhaps a rehabilitation center, an epileptic clinic, a child guidance center, or a mental hygiene out-patient clinic. In any case he can advise the patient where to obtain the most adequate help at a reasonable cost. The doctor is a highly effective link between the special services.

Industry and business are adding new functions to their responsibility in this field, demanding more occupational diagnostic facilities to take care of on-the-job problems. From the economic viewpoint alone it is highly wasteful to employ a person for years, only to discharge him for a minor offense. All his accumulated experience is then suddenly thrown away. Or a firm spends hundreds, even thousands, of dollars training another person who can never fit into the job waiting for him. When a company invests in expensive technological equipment and fails to recognize the effects of the new gadget on group morale, the result may be disastrous. Sudden absenteeism may simply enrage a foreman who "chews out" the man or fires him before discovering that his wife has just had a miscarriage. And so on. The impersonality of highly organized and bureaucratic corporations make the problem of mental health in this highly structured social system a matter of ever-graver concern. Personnel methods, employee counselling, and industrial medicine have too often worked independently on the subject. In the future a new collaboration of all these will be needed, a team approach that includes not only management but union labor. It will rest on the conviction that the worker in the plant or office is only a segment of a total human being, bringing with him his financial, domestic and social difficulties from home or community. In the past, industry has regarded morale problems as appearing only in its own domain; but the time is coming when it will need the same cooperative attitude and community-agency-dependence already developing in schools, churches, and the medical profession.

Public health authorities have an enviable record for reducing the incidence of communicable infections; today they are enlarging their operations to include the prevention of personality disorders. But the new task is far more difficult. It has no clear outline, no isolable pathogen. An approach to mental health calls for a way of life, not a simple quarantine or detection of micro-organisms.

But public health has had ample experience with parallel programs in nutrition and infant care. The National Mental Health Act makes it possible to expand public health services and give them a new impetus. Some federal funds have already gone into community diagnostic and treatment clinics. But both on the state and national level, departments of health recognize that treatment facilities are not enough, that special training for health officers, public health nurses and teachers is imperative. They are also initiating a broader program to present mental health concepts to the public, in industry, professional groups and the public schools. The Division of Mental Hygiene of the United States Public Health Service is assuming an even more important task—research on social etiology of mental disorders. A number of states are pursuing new experiments in the field. Oregon and Minnesota have developed psychiatric refresher courses for general physicians, sensitizing them to their role in early discovery and treatment of mild neurotic cases. New Jersey has set its goal as the reaching of every family with prophylactic guidance given by public health nurses in both physical and mental health. Several state health departments are coordinating their efforts with the federal agency to promote preventative mental health goals.

One of the most extensive prophylactic programs is sponsored under private auspices. The Delaware State Society for Mental Hygiene has developed a course for elementary school children entitled *Human Relations in the Classroom*. At latest report, over 200,000 children have enrolled in such classes in Delaware and other states. The weekly class begins with the teacher reading a stimulus story featuring emotional problems. She then encourages pupils to discuss the problem, the solution offered, the motivations involved, and parallels from their own experience. As the course progresses, it leads to personal practice in making decisions, accepting responsibilities, learning from one's own emotional mistakes, making and keeping friends, bringing fears out into the open, carrying on when emotionally disturbed, looking at unknown future changes as adventures to be faced. Results of this venture have proved encouraging and can be incorporated into wider community programs that draw in adults. Would it be more feasible to put more public money into this sort of experiment than into building new state hospitals and clinics? Perhaps it is not an either-or-proposition, but considering the millions of dollars expended for those whose condition may be incurable, what can we say of the shortsighted-

ness that prevents at least an equal outlay for social reenforcement of the growing personality during the years of potential unbalance?

Granted that psychiatry is becoming more social, granted that community organization and co-ordination of services is spreading, and granted that mental health is everybody's job, we may ask one final question. If civilization itself is in decline, if economic tensions, race conflict and incipient wars threaten to undo man's constructive efforts, are not the plans for mental health futile or even irrelevant in view of the larger concerns? If the specter of war draws closer and closer, should not the task of international peace demand priority? If war comes and disrupts all our fine schemes, what good have they done? If society is "sick," and cultural conflicts endemic in our way of life, why play with palliatives and neglect the larger task of reorganizing society itself?

There is, of course, no final answer to these queries. But the social scientist is quite undismayed by them. He inevitably thinks in pluralistic terms, refusing to acknowledge that action on larger problems excludes action on what appear to be smaller ones. The death of social structures does not mean the death of society. In the meantime, if we release the energies of social science to create more balanced and flexible personalities for tomorrow, our preoccupation with the human qualities of the next generation may result in the greatest gift we could bestow on posterity. For the society of the next generation will need such personalities in abundance, whether it is ravaged by destructive forces, or whether it manages, at the last minute, to turn the corner into a more peaceful future.

FOUR

The Field of Social Psychiatry *

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A REVIEW of the contacts between psychiatry and sociology in the United States¹ points to the fact that a field of research area called "social psychiatry" has emerged even though somewhat fitfully. This has resulted from the attempt to study certain problems considered as psychiatric from the point of view and with the techniques of the sociologist. A semantic difficulty immediately arises, however, when it is recognized that other "social" disciplines,

* Paper read before the annual meeting of the American Sociological Society, New York City, December 28-30, 1947. From *American Sociological Review*, 13 (April, 1948), 183-197. Reprinted by permission of the author and the publisher.

¹ The first indication, perhaps, of a psychiatric influence on sociology came in 1917 when Groves' article, "Sociology and Psychoanalytic Sociology," appeared in the *American Journal of Sociology* (Vol. 23, 1917, pp. 107-116). At the annual meeting in 1920 Groves and Gehlke jointly presided at a roundtable on the "Sociological Significance of Psychoanalytic Psychology." This interest was not continued in 1921, but in 1922 a new section "Psychic Factors in Social Causation," appeared on the program, at which Ogburn presented a paper, "Psychoanalysis and the Subjective in Relation to Sociology." From then nothing of significance happened until at a meeting of the Executive Committee of the Society on December 29, 1927, President W. I. Thomas read a statement from Dr. Harry Stack Sullivan of the American Psychiatric Society, which suggested that a committee from the American Sociological Society be appointed to confer with a committee from the American Psychiatric Society on plans for promoting their joint common interests. Such a committee was appointed.

At the next annual meeting, the committee on the Relations of Sociology and Psychiatry (W. I. Thomas, Kimball Young, and R. E. Park) reported that a joint colloquium on personality investigation was held in New York City. In addition, the Committee on Sections reported that "Psychiatry and Sociology" met for the first time under the chairmanship of the late Professor Robert E. Park. This section continued to meet, except in 1934, as part of the annual program until 1941, when it met for the last time. At the annual meetings in 1943 and 1946, this section did not meet. Only once, in 1932, under the chairmanship of Thomas Eliot was the section labelled "Social Psychiatry" instead of "Sociology and Psychiatry."

namely psychoanalysis, psychology, and anthropology, also have studied psychiatric problems from their respective viewpoints and with their various techniques. It is a difficulty because it questions the proposition that a field of social psychiatry should be regarded as exclusively the product of the sociologists.

The more formal professional relations between psychiatry and sociology during the past twenty years as reflected in committee reports, joint meetings, and annual programs, only serve to publicize a relationship which, at least in the minds of certain members of the respective societies, had been present for some time.² True, the initial psychiatric influence in sociology had come via psychoanalysis and true also that among the psychiatrists there were research-minded men of the high caliber of W. A. White, William Healy, Trigant Burrow, Charles Campbell, and Adolph Meyer, who in their researches were increasingly coming up against problems which were not only sociological in character, but which demanded the specialized training of a sociologist.

CONVERGING PERSPECTIVES

The question as to whether a field of social psychiatry has been developed is certainly a moot one. It may be possible to come closer to this issue by examining the kind of psychiatric interest manifested by the various social disciplines tangential to psychiatry. In so doing, we will also be able to evaluate any conception of a "social psychiatry" emerging from these disciplines or held by them.

It can, no doubt, be said in fairness to all of the disciplines concerned, that the workers in sociology have been the most avid and aggressive in attempting to mark out the boundaries of such a field. Brown, Dunham, Folsom, Groves and Krout have written articles dealing with the supposed field of social psychiatry.³

² William White presiding at the First Colloquium on personality investigation stated in his opening remarks, "... but fortified by the profound conviction that has been forced upon us for many years that psychiatry, with the material it has to deal with, is dealing with conditions that are essentially different from the materials which general medicine deals." See "Proceedings of First Colloquium on Personality Investigation," *American Journal of Psychiatry*, 8 (1928-29), 1019-1177.

³ See L. Guy Brown, "The Field and Problems of Social Psychiatry." In *The Fields and Methods of Sociology*, L. L. Bernard (Ed.) Ray Long and Richard R. Smith Publishers, New York: Part I, 129-145. H. Warren Dunham,

From these authors, three emphases might be said to emerge. These are (1) the attempt to relate the field of social psychiatry to general psychiatry and the larger area of psychopathology (Krout); (2) to point out some of the problems which make up social psychiatry and which deal with the possible relationship of some environmental variable to some psychiatric syndrome (Brown, Dunham, Folsom); and (3) to show the converging research lines of development making for a social psychiatry (Groves).

In terms of research ⁴ it seems that the field of social psychiatry has encompassed studies showing correlations of certain personality disorders or maladjustments with some variable derived from the social environment. To sum up, one might say that the sociologist has attempted to carve out and delimit a so-called field of social psychiatry ⁵ in a direct proportion to the research effort expended on satisfactorily explaining personality disorders and group maladjustments.

In contrast to the sociologist, the cultural anthropologist has shown no need to develop or even to speak about a "social psychiatry." On the one hand, he has been busily engaged in incorporating certain psychoanalytic principles into his thinking in order to sharpen his analysis of behavior and personality in alien cultures. On the other hand, he has been concerned with the necessity to synchronize psychoanalytic armchair anthropology with field research anthropology concerning the genesis and nature of human culture. Kluckhohn has given a competent and detailed account of the re-

"The Development of Social Psychiatry," *Mental Health Bulletin*, Illinois Society for Mental Hygiene, XVIII (March-April 1940), 4-7.

Joseph K. Folsom, "The Sources and Methods of Social Psychiatry." In *The Fields and Methods of Sociology*, L. L. Bernard (Ed.); Ray Long and Richard R. Smith Publishers, New York: Part II, 387-401. E. R. Groves, "The Development of Social Psychiatry," *Psychoanalytic Review*, XXII (Jan. 1935) 1-9. Maurice H. Krout, "The Province of Social Psychiatry," *Journal of Abnormal and Social Psychology*, XXVIII (1933-34), 155-159.

⁴ The account of the developments in social psychology during the thirties by Cottrell and Gallagher has included many of the newer viewpoints and examples of research which have come to be regarded as a part of social psychiatry. Cottrell and Gallagher include them in their article because of the broad encompassing conception which they think is expressive of contemporary social psychology. See their *Developments in Social Psychology* (1930-1940), Sociometry Monograph No. 1, 1941, pp. 1-58.

⁵ It is of passing historical interest to note that the term, "social psychiatry," is used by the *American Journal of Sociology*. See "Selected References on Social Psychiatry," XLII (May 1937), 891-894.

reciprocal influence of anthropology and psychiatry in the United States.⁶

Perhaps, more than either the anthropologist or the sociologist, the psychologist has felt a constant and continuing relationship with the kind of problems faced by the psychiatrist. The numerous textbooks of abnormal psychology written by both psychiatrists and psychologists demonstrate this mutual inter-penetrating interest.⁷ Then, too, in their research—omitting from consideration animal psychology—the psychologists have attempted to study objectively (1) the specific mental mechanisms of man, (2) the development of the child in society and (3) the nature of personality—all of which are of interest to the psychiatrists. These three areas of interest frequently involved the abnormal and bizarre in mental reactions as well as the maladjustments of persons living in society. The psychologists were quick to develop their own theories for certain mental diseases and to amass a body of evidence which served to support their theories.⁸ Some of their work here is reflected in the various tests developed which were diagnostic of personality traits, intellectual traits, and sometimes psychiatric syndromes. Unlike the sociologists, who only recently have shown specific interests in the abnormal mental life, the psychologists have had no need to carve out any special field to encompass their research interests as the field of abnormal psychology always proved adequate.

Psychoanalysis in its orthodox form⁹ has succeeded in building

⁶ "The Influence of Psychiatry on Anthropology in America During the Past One Hundred Years," in *One Hundred Years of American Psychiatry, 1844-1944*. New York: Columbia University Press, 589-617.

⁷ For such examples, see Bernard Hart, *The Psychology of Insanity* (Fourth Edition), New York: The Macmillan Company, 1931. A. Myerson, *The Psychology of Mental Disorders*, New York, 1927. R. M. Dorcus and G. W. Shaffer, *Textbook of Abnormal Psychology*, Baltimore, Williams & Wilkins, 1934. William McDougall, *Outlines of Abnormal Psychology*, New York: Charles Scribner's Sons, 1926.

⁸ See M. Sherif and H. Cantril, *The Psychology of Ego Involvements*, New York: John Wiley and Sons, Inc., 1947. See especially Chaps. 12 and 13. G. W. Kisker and G. W. Knox, "The Physico-Social Basis of Mental Disorder," *Journal of Nervous and Mental Disease*, 93 (1941), 163-168. G. W. Kisker and G. W. Knox, "The Psychopathology of the Ego System," *Journal of Nervous and Mental Disease*, 96 (1943), 66-71; "The Psychologist's Contribution to the Study of the Mental Patient," *Journal of Personality*, 15 (Dec. 1946), 93-141.

⁹ In speaking of the orthodox form of psychoanalysis our intention, of course, is to refer only to the views of Freud and his intellectual advocates.

a closed system of psychological psychiatry. It has a theory of the growth and development of the human personality which is deterministic, dynamic, substantial, exclusive and pragmatic. It has a system of therapy which rests upon its body of theory. Like any body of scientific knowledge, it began with certain problems and emerged as a body of theory and generalizations for explaining those problems. Through its literature, techniques, therapeutic results, and propaganda, it has established itself as a branch of medicine and particularly of psychiatry.¹⁰

Psychoanalysis through its theory, its research techniques, its psychologism and its intellectual pretensions in other scientific areas has had a much closer intellectual affinity with the social sciences than with the biological and natural sciences. Specifically, it aligns itself with social psychology and sociology in its emphasis upon the family constellation and its account of the emotional ties between fathers and daughters and mothers and sons. Again, in placing emphasis upon the errors of every-day life and upon the meanings of dreams, psychoanalysis was calling attention not only to the unconscious in which these forgotten experiences were hidden, but also to the emergence, form and content of human experience as it took place in a social context. What could be more social psychological than this?

Again, specifically, psychoanalysis branched out in its system of sociology¹¹ and challenged certain anthropological conceptions of the origin, nature and functioning of human culture. The com-

We are well aware that certain of Freud's rebellious sons, Adler, Jung, Rank, and Stekel, have in their writings exerted definite influences on social science. Jung's "psychological types" and Adler's concepts of "organ inferiority" and "style of life" have frequently been useful in sociological analysis. However, we feel that to discuss all of these influences, in detail, significant as some of them are and may prove to be, would carry us beyond the scope of this paper.

¹⁰ See for example, A. A. Brill, *Freud's Contribution to Psychiatry*, New York: W. W. Norton and Co., 1944. See also Theodore Van Schlevlen, "Psychiatry and Psychoanalysis," *International Journal of Psychoanalysis*, X (1929); Sandor Rado, "Psychoanalysis and Psychiatry," XVII (1936), 202-205. Also Leland Hinsie, "The Relationship of Psychoanalysis to Psychiatry," *American Journal of Psychiatry*, 91 (1935), 1105-1115. These references are only suggestive. The literature is replete with articles dealing with this relationship.

¹¹ Freud's sociological system is found in the following works: S. Freud, *Totem and Taboo*, New York: Moffat, Yard and Co., 1918; *Group Psychology and the Analysis of the Ego*, London, 1921; *The Future of an Illusion*, London, 1928; and *Civilization and Its Discontents*, London: Hogarth Press, 1930.

plete biologism that all human institutions were basically to be understood as being genetically an outgrowth of man's instinctual life was unsatisfactory in its failure to square with the empirical formulations of social scientists. The resulting critical appraisal by the social scientist of Freudian sociology produced a situation of mutual inter-stimulation between the psychoanalysts and cultural anthropologists. Thus, at the points where its theory cuts across or into the theory of other scientific disciplines about psycho-social reality and in the attempts to square its theory with other competing or existing theories, psychoanalysis enters into and becomes a part of that body of scientific knowledge which seeks to explain the bizarre and peculiar psychic states of man and the difficulties of behavior in man which can be observed as a distorted aspect of the rubric of social life. Psychoanalysis as a dynamic psychology of mental life must mesh eventually with a dynamic sociology of inter-personal and cultural relationships.

We have been concerned with the respective roles of sociology, cultural anthropology, psychology, and psychoanalysis in relation to the problems presented by the neuroses, psychoses, and other psychopathies among humans in society. Thus, these disciplines have tended to cope with certain problems relating to the aberrations of man's mental life which traditionally have been regarded as the province of psychiatry. Now, psychiatry, narrowly defined, is that branch of medicine which deals with the study, diagnosis and treatment of mental disturbances and diseases. However, this narrow conception of psychiatry proved in many instances singularly unsatisfying to the intellectual leaders in the field as they began to contemplate the character of their problems and materials and to glimpse the research and thinking about the neuroses and psychoses which were being carried on by other scientific fields. Two recent emphases can be cited (although there are others) of the attempt of psychiatry to get out of its traditionally rather tight clothing. The first is found in the writings of Harry Stack Sullivan. Sullivan sees modern psychiatry as a union of two strains of thought—one leading back to the Hippocratic school of medicine and concerned with the art of observing and treating mental disorders—and the other strain of thought concerned with the genesis of man as a social being. In psychiatry the three men who helped to bring these two intellectual strains together were Freud, Meyer and White. But Sullivan adds,

This synthesis is not yet complete. The next, I trust, great step in its emergence came with the realization that the field of psychiatry is neither the mentally sick individual, nor the successful and unsuccessful processes that may be observed in groups and that can be studied in detached objectivity. Psychiatry, instead, is the study of processes that involve or go on between people. The field of psychiatry is the field of interpersonal relations, under any and all circumstances in which these relations exist. It was seen that a *personality* can never be isolated from the complex of interpersonal relations in which the person lives and has his being.¹²

Thus, Sullivan would extend the conception of psychiatry so that it is coterminous with much of what sociologists regard as the field of social psychology today. In fact, many of Sullivan's concepts such as empathy, social acts, the self, the personal world, and social interaction are reminiscent of the older social thought of Cooley, Dewey and Mead.

A second attempt to broaden the traditional conception of psychiatry is shown rather clearly by Masserman's recent textbook in the field. On the first page of this work is to be found the statement, "Psychiatry can be broadly defined as the science of human behavior."¹³ Psychiatry is apparently to usurp the role—which sociology was at one time pressed to occupy—as the great synthesizing science of all the sciences dealing with human behavior.

Now, it is not our intention to be critical of these broadening conceptions but rather to point to the fact that they were inevitable—invisible if it is recognized that the kind of data with which medicine traditionally had to deal was neither sufficient nor useful in answering all of the questions which psychiatrists were asking. As the social sciences have reached out to study problems of a psychiatric nature, so has psychiatry extended itself to embrace the methodological positions, data and techniques of those social disciplines.

We have now come to a point in the development of our thesis where we can raise the question: "What is social psychiatry anyway?" The answer is that it is pretty much a creation of the

¹² "Conceptions of Modern Psychiatry," *Psychiatry*, III (Feb. 1940), 4-5.

¹³ Jules H. Masserman, *Principles of Dynamic Psychiatry*, Philadelphia: W. B. Saunders Co., 1946, p. 1. Along a similar line Zilboorg argues that psychiatry must create its own sociology and that clinical psychiatry has partially succeeded in doing this. See Gregory Zilboorg, "Psychiatry as a Social Science," *American Journal of Psychiatry*, 99 (Jan. 1943), 585-588.

sociologists to designate the interests of certain of their numbers who are doing research in the field of personality disorder or, following Folsom, are trying to find meaningful correlations between various types of personality disorders and certain variables in the realm "of social interaction, social environment, or culture."¹⁴

But the anthropologist and the psychologist have also been concerned with these interests and the development of similar correlations. Workers in these fields are no less working in "social psychiatry" even though they have not applied the label. The term, social psychiatry, thus appears to be at best a misnomer or at the worst an unfortunate term when linked in any exclusive sense with sociology. It is certainly not "psychiatry" even though the problems as represented by the neuroses and psychoses may have traditionally belonged to the field of psychiatry. It is certainly not "social" merely because sociologists have done some of the work in any greater sense than would be other such research work which might be carried on by anthropologists, psychologists, or psychoanalysts.

What has happened is that the kinds of problems present in the field of psychiatry are ones which cannot be approached and solved exclusively within the framework of the biological sciences. For in the psychiatric sphere particularly medicine needs the cooperation, the insights and the viewpoints of the social sciences.¹⁵ This position is all too clearly reflected in the attempts already described of Sullivan and Masserman to extend the traditional boundaries of psychiatry.

What seems to be developing in terms of a broader psychiatry and the research concerns of these other disciplines is the general recognition among workers in these various fields that there exists a particular constellation of problems centering around the deviant character of various mental processes in man, the deviant character

¹⁴ See J. Folsom, *op. cit.*, p. 387.

¹⁵ See Herman M. Adler, "The Relation between Psychiatry and Social Sciences," *American Journal of Psychiatry*, VI (April, 1927), 661-670. It is of interest to note that Adler considers the psychiatric social worker as the practitioner for psychiatric problems within the social sciences. The same position is somewhat implicit in Samuel W. Hartwell's, "Social Psychiatry—Our Task or a New Profession," *The American Journal of Psychiatry*, 19 (March, 1940), 1089-1104. Hartwell makes a plea for the adequate training of psychiatric social workers in order to make them real assistants to the psychiatrists. Incidentally, this is the only time to our knowledge that a psychiatrist has used the concept, "social psychiatry," and this in a context completely different from that in which the sociologists have used it.

of man's behavior, and the role and function of such deviations as they evolve in society. Such deviations which we have broadly described run all the way from mild peculiarities of behavior to the extreme forms of psychoses.¹⁶

In this range of behavior forms is a set of problems which require the attention both independently and cooperatively of workers in the social sciences as well as in the biological and medical sciences. In attempting to carve out such a field, we have before us an analogous situation represented by criminology. Here is a scientific field concerned with explaining various kinds of behavior which do not have sanction by the dominant group in human society. In addition, the field is concerned with the handling, control and rehabilitation of such persons. Now the valid and reliable knowledge in this field has been built up by the joint efforts of sociologists, psychiatrists, anthropologists, psychologists, psychoanalysts and other workers.¹⁷

It is precisely something analogous to criminology which is pressing for emergence via the problems of etiology, control, and therapy of those persons whose mental peculiarities make them strange to other persons in society. The label for such a field is much less certain than the fact of its existence as attested by the research contributions to this problem area by the various social, psychological and biological sciences. No doubt, its eventual label will be dependent upon the reliability and validity of the knowledge which eventually emerges from the researches of the various sciences involved.

We would now like to consider some of the specific kinds of knowledge which have been developed by the sociologists and cultural anthropologists during the last fifteen years¹⁸ and which in

¹⁶ While we are not committed here to regarding all forms of abnormal behavior as constituting one continuum, it is of interest here that a psychiatrist writes, "The conviction is becoming widespread among psychiatrists, psychologists, and sociologists, that the same kind of personal, social and environmental factors are operating in preparing the ground for and in precipitating the functional psychoses as in the case of the neuroses." See N. Cameron, "The Functional Psychoses," in *Personality and Behavior Disorders* (J. McV. Hunt), Vol. II, New York, Ronald Press Co., 1944, 861-921.

¹⁷ In Great Britain a post-war institution has evolved which brings together all the social sciences, including psychiatry, for a joint attack on social problems. See Jacques Elliott, "Some Principles of Organization of a Social Therapeutic Institution," *Journal of Social Issues*, III (Spring, 1947), 4-10.

¹⁸ Thus, we are dating this from 1932, when the status of the various fields of sociology was appraised at the annual meetings. See L. Guy Brown, "The

the hands of the sociologists have been labelled "social psychiatry." It is not our intention to cite every isolated piece of research¹⁹ which has been reported but (1) to point out the major areas developed, (2) to give some evaluation of their significance, and (3) to show the emergence of certain crucial problems. During this period there seem to have been four general areas of research which have been exploited and which have yielded results of varying significance. These four areas include studies which can be designated as: (1) ecological and statistical, (2) personality and culture, (3) caste and class, and (4) interpersonal relations.

ECOLOGICAL AND STATISTICAL STUDIES

Since 1939 when Faris and I reported on the results of our ecological studies of mental disorder in Chicago and Providence,²⁰ a number of other similar studies have appeared which have served as a check on our original findings. Reference is made to the studies of Green,²¹ Mowrer,²² Queen,²³ Schroeder,²⁴ and Hadley.²⁵ The major findings of our ecological studies are fairly well known and

Fields of Social Psychiatry," and Joseph K. Folsom, "The Sources and Methods of Social Psychiatry," *op. cit.*

¹⁹ We are concerned here largely with the recent researches of the sociologists and cultural anthropologists. However, many psychiatrists and psychoanalysts through their writings and researches are contributing to the building of a "social psychiatry." See for example, James Plant, *Personality and the Cultural Pattern*, New York, 1937. Paul Schilder, "The Social Neurosis," *Psychoanalytic Review*, XXV (January, 1938), 1-19; Paul Schilder, "The Sociological Implications of the Neuroses," *Journal of Social Psychology*, XV (1942); Freda Fromm-Reichmann, "Remarks on the Philosophy of Mental Disorders," *Psychiatry*, IX (November, 1946), 293-308.

²⁰ See Robert E. L. Faris, and H. Warren Dunham, *Mental Disorders in Urban Areas*, Chicago: University of Chicago Press, 1939.

²¹ H. W. Green, *Persons Admitted to the Cleveland State Hospital 1928-37*, Cleveland Health Council, 1939.

²² E. Mowrer, "A Study of Personal Disorganization," *American Sociological Review*, IV (August, 1939), 475-487. See also his *Disorganization—Personal and Social*, New York: J. B. Lippincott Co., 1942, Chapters 15 and 16.

²³ Stuart A. Queen, "The Ecological Studies of Mental Disorder," *American Soc. Rev.*, V (April, 1940), 201-209.

²⁴ C. W. Schroeder, "Mental Disorders in Cities," *American Journal of Sociology*, 47 (July, 1942), 40-47.

²⁵ E. E. Hadley and Others, "Military Psychiatry—An Ecological Note," *Psychiatry*, VII (November, 1944), 379-407.

there is no intention of reviewing them here.²⁶ Rather, our concern will be to note the extent to which the other studies check and agree with the findings for Chicago. There seems to be one point upon which all the studies are in agreement, namely, that all types of mental disorder in their distribution in the city show a wide range of rates with the high rates concentrated at the center of the city and declining in all directions toward the periphery. Thus, Schroeder concludes in his summary of the evidence that "insanity areas" have been shown to exist. Ecological distributions of mental disorders in nine cities support this finding.

However, while some agreement exists, it is by no means universal with respect to the distribution of the various kinds of psychoses. Our major finding concerning the difference in the distribution of schizophrenia and manic-depressive psychosis has not been conclusively substantiated. There is still less agreement with respect to the toxic and organic psychoses. The correlation which we originally reported between many of the distributions and various indexes of socio-economic level and social solidarity are likely to show marked shifts if new samples are secured. Queen²⁷ has pointed to the need for more refined indexes for measuring specific community conditions and for investigators to agree on the same index in order to facilitate comparisons.

Various explanations for the patterns of the rates as found have appeared from time to time. These include the "selective character of cases going to state hospitals," the "drifting hypothesis,"²⁸ the "lack of significant statistical difference between the rates,"²⁹ and the "statistical illusory quality of the rates due to mobility."³⁰ Answers have been given for all of these critical hypotheses and, if they have not been conclusively annihilated, much doubt has been cast on their validity for disposing of the significance of the various rate patterns, namely, the pointing to the role of the social en-

²⁶ For an excellent review, see R. E. L. Faris, "Ecological Factors in Human Behavior," In *Personality and Behavior Disorders* (J. McV. Hunt, Ed.) Chapter 24, New York: The Ronald Press Co., 1944, 736-757.

²⁷ *Op. cit.*

²⁸ See review of *Mental Disorders in Urban Areas* by A. Myerson, *American Journal of Psychiatry*, 96 (January, 1940), 995-997.

²⁹ F. A. Ross, "Ecology and the Statistical Method," *American Journal of Sociology*, 38 (January, 1933), 507-522.

³⁰ A. J. Jaffe and E. Shanas, "Economic Differentials in the Probability of Insanity," *American Journal of Sociology*, 44 (January, 1935), 534-539.

vironment as a broad, general etiological agent for these various disorders.

In a recent article ³¹ I have already set down my chief criticism and evaluations of these ecological studies and so, now, I wish merely to quote the final paragraph.

. . . Queen and others point to the need for more complete life histories of persons who develop these psychoses in contrast to those who do not in the same community setting. Perhaps, but one can never know this, the ecological studies may have stimulated demands for the above type of study. Be that as it may, the concluding note would appear to be that these studies have provided important and useful information about our community life; they have revealed little that is significant about the etiological factors which lie behind the various types of mental disorder.

Let us now turn to a consideration of studies of the distribution of mental disorder through time. These studies are of less value than those of spatial distribution. This is due to the lack and inadequacy of the statistics over long periods of time in different places. The pressing question as to whether mental disorder is increasing cannot be satisfactorily answered. Winston,³² Dorn,³³ and Elkind³⁴ question an increase while Malzberg³⁵ on the basis of his statistics of mental disease in New York State thinks there has been an increase beginning with the final decade of the last century. Malzberg concludes that the unwillingness to recognize the in-

³¹ See H. Warren Dunham, "The Current Status of Ecological Research in Mental Disorder." *Social Forces*, 25 (March, 1947), 321-326. (No. 10 in this volume.)

³² E. Winston, "The Assumed Increase of Mental Disease," *American Journal of Sociology*, 40 (January, 1935), 427-429.

³³ H. F. Dorn, "The Incidence and Future Expectancy of Mental Disease," *Public Health Reports*, 53 (November 11, 1938), 1991-2004.

³⁴ Henry B. Elkind, and M. Taylor, "The Alleged Increase in the Incidence of the Major Psychoses," *American Journal of Psychiatry*, 92 (January, 1936). See also J. S. Jacobs, "A Note on the Alleged Increase of Insanity," *Journal of Abnormal and Social Psychology*, 23 (1938), 390-397. Jacobs argues that an increase in the number of beds accounts for an increase in first admissions. I find it generally difficult to accept this argument because it seems to imply that an increase in the number of beds causes us to detect cases in order to fill the beds rather than the reverse that an increase in the number of mentally disordered in the community makes for a pressure on the community to provide more beds—and realistically, most communities in the United States are not likely to provide beds until absolutely necessary to do so.

³⁵ See his *Social and Biological Aspects of Mental Disease*, Chapt. 1, Utica, N.Y., State Hospital Press, 1940.

crease in mental diseases is due largely "to disputes between eugenicists and environmentalists." In making five different assumptions about the future fertility and mortality rates, Tietze shows that the trend of rates till the year 2000 is upward and thus tends to support the Malzberg position.³⁶

With respect to the statistical studies of mental disorder, I am pointing to those counts of the incidence of the various kinds of mental disorder in relation to certain individual attributes such as age, sex, nativity, and race, or in relation to such status conditions as marital, income, education, occupation, religion or mobility. A difficulty arises in making an interpretation of the rates as found, for the findings of such statistical counts are generally used to support one methodological position as over against another.³⁷ Such findings have also been used to advance certain hypotheses which, for the most part, are never tested by collecting and organizing other relevant data.

It is of some significance to note that the ecological and statistical studies of mental disorders have been carried on apart from the other research developments in the sociological field dealing with similar problems and apparently have had very little influence on these other developments. This is very surprising when one considers that these studies have pointed to various problems which might be studied by more elaborate research techniques. The challenge which they present, however, is seldom accepted.

CULTURE AND PERSONALITY STUDIES

The earlier notion of anthropologists that human personality is somehow a constant variable, the idea represented by Cooley of the universality of human nature, and the conception that human personality is the "subjective aspect of culture" all have been re-examined by the researches of the social anthropologists during the

³⁶ Christopher Tietze, "Future Trends of Mental Disease in the United States 1940-2000," in *Trends of Mental Disease*, The American Psychopathological Association, 1945, pp. 11-25.

³⁷ See for example, C. Landis and J. Page, *Modern Society and Mental Disease*, New York, Farrar and Rinehart, 1938; C. Tietze, B. Lemkau, and M. Cooper, "Personal Disorder and Spatial Mobility," *American Journal of Sociology*, 48 (July, 1942), 29-39. Also Rosalind Gould, "Social Factors in Psychopathology," *The Psychologists League Journal*, III (May-August, 1939), 53-58; O. Odegard, "Emigration and Mental Health," *Mental Hygiene*, XX (October, 1936), 543-556.

past two decades. The four emphases which have developed from these researches include: (1) the attempt to describe a culture in terms of some dominant theme which runs through the entire society, (2) the relativistic character of personality deviation, (3) the formulation of the idea of basic personality structure moulded by a specific culture, and (4) the reformulation of the psychoanalytic anthropology which had viewed human institutions as largely an extension of the instinctual life of the individual.

Ushering in this era of anthropological research is Margaret Mead's 1928 account of the socialization of the child in Samoa.³⁸ Mead attempted to show that "storm and stress" usually expected to accompany adolescence by our standards was not true for Samoan society and the harmonious and easy adjustment of the Samoan adolescent was related to the nature of the family organization. In later researches, Mead tends to emphasize the same position by pointing to the different cultural definitions attached to the sexual act and play activity in different societies and how these things affect the person's growing up in the society.³⁹

Benedict⁴⁰ in her research attempts to show that contrasting themes labelled by the Apollonian-Dionysian dichotomy run the entire gamut of Zuni and Plains Indian cultures. Then, by examining the extreme paranoia which runs through the Dobu society and the giving away of one's goods as a means of subduing a rival so typical of the Kwakiutl, Benedict is able to show that tendencies and conditions which in our society are regarded as abnormal are essential qualities of the ideal man in the Indian culture of the Northwest Coast. Thus is portrayed, even though not conclusively, the relativistic character of certain traits which in our society are regarded as abnormal. In other societies, such traits become channelized and institutionalized in the cultural patterns of the society.⁴¹

³⁸ *Coming of Age in Samoa*, New York: Morrow & Co., 1928.

³⁹ See M. Mead, *Sex and Temperament in Three Primitive Societies*, New York: Morrow and Co., 1935. Also see her *Cooperation and Competition Among Primitive Peoples*, New York: McGraw-Hill & Co., 1937.

⁴⁰ See Ruth Benedict, *Patterns of Culture*, New York: Houghton Mifflin Co., 1934 and see also "Anthropology and the Abnormal," *Journal of Genetic Psychology*, 10 (1934), 59-82.

⁴¹ A. I. Hallowell, "The Social Function of Anxiety in a Primitive Society," *American Sociological Review*, VI (December 1941), 889-891; see also his "Psychic Stresses and Cultural Patterns," *American Journal of Psychiatry*, 92, 1291-1310.

Another viewpoint in recent anthropological research has been emphasized by Kardiner and his collaborators who have attempted to use psychoanalytic techniques and insights in the analysis of cultural data. In their first volume⁴² the attempt was made to show for two cultures the manner in which the basic personality structure is derived from the primary institutions such as the relation between the sexes, child training devices, subsistence techniques and the like. Thus, the notion of the basic personality structure is presented as a technique for better understanding cultural patterns and institutions. The basic personality structure consequently rests upon the postulate that if the child training devices are the same in all families of a given culture, the personality organization will not vary between individuals. But, atypical family training, in contrast, is likely to produce some type of deviant personality. The basic personality structure can be regarded as projective into the culture and thus accounting for the various secondary institutions appearing in the culture.

If this account of the basic personality structure can be considered as valid, it was thought that it might be constructed by the study of a given culture *per se*. In his second book,⁴³ Kardiner attempts this through the analysis of the cultural and psychological materials obtained by Du Bois in her study of the Alorese.⁴⁴ By studying such primary institutions as child training practices and certain conditionings for adult life, an attempt was made to show the kind of basic personality structure emerging in the society. The concept of basic personality structure then came to be regarded as a tool for social science research.⁴⁵

The research work of Mead, Benedict, Dollard and Warner in various culture milieus had a certain impact on psychoanalytic psychiatry. Here, Horney⁴⁶ took the lead by viewing the neurosis not as, in the past, a result of repression of libidinal energy or the

⁴² A. Kardiner, *The Individual and His Society*, New York, Columbia University Press, 1939.

⁴³ A. Kardiner, *The Psychological Frontiers of Society*, New York, Columbia University Press, 1945.

⁴⁴ Cora Du Bois, *The People of Alor*, Minneapolis, University of Minnesota Press, 1944.

⁴⁵ See A. Kardiner, "The Concept of the Basic Personality Structure as an Operational Tool in the Social Sciences," in *Science of Man in the World Crisis*, New York, Columbia University Press, 1945, pp. 107-122.

⁴⁶ Horney, although a psychoanalyst, has been included here both because of her influence in shaping the neo-freudian position and because of her influence among sociologists.

fixation of the emotional life at some point in its development, but rather in terms of the conflicting demands which a given culture imposes on the individual.⁴⁷ She also attempts to find for our society that the competitive patterns contain the seeds of the aggressive strivings and ambivalent hostility which are characteristic of our neuroses.⁴⁸ In a later work, dissatisfied with therapeutic results and certain phases of psychoanalytic theory, she attempts to bring psychoanalysis in line with the newer conceptions in sociology and anthropology and to substitute a "sociological orientation" for an "anatomical-physiological" one.⁴⁹

These culture and personality studies have been suggestive rather than conclusive and it would seem that this position can be maintained with respect to any aspect which one might desire to examine. The conclusion is the same whether one tries to find *a la Kardiner* the exact procedure by which the group culture makes ingression into the personality as "key integrational systems" or whether one tries to get a picture of the relativistic character personality deviations as Mead, Benedict and Hallowell do. With respect to the Kardiner group, it can be pointed out that there is no systematic statement of hypotheses or concepts so that it is frequently difficult to follow them. Then, too, while the basic personality structure may be formed in the childhood years through the operations of the primary institutions, the materials on the various cultures largely illustrate this conception; they do not demonstrate or prove the hypothesis. With respect to the relativistic character of personality deviations, it would seem that the main contribution of these workers is to show that certain behavior forms which have been viewed in our society as psychiatric symptoms are in certain other societies often channellized by the prevailing institutional structures or perform a given function in relation to the total culture. This may be all right as far as it goes but it certainly does not succeed in explaining how these symptoms frequently combine in a person to display a complex deviant mental disturbance which we in our society recognize as one of the functional psychoses. Anxiety or trance-like states which may be

⁴⁷ K. Horney, "Culture and Neurosis," *American Sociological Review*, I (April, 1936), 221-229.

⁴⁸ K. Horney, *The Neurotic Personality of Our Time*, New York, W. W. Norton and Co., 1937.

⁴⁹ K. Horney, *New Ways in Psychoanalysis*, New York, W. W. Norton and Co., 1939.

functionally useful in certain cultures is one thing; schizophrenia, one of our diagnostic labels for a functional disorder, is something else again. I am not saying that no attempt should be made to study schizophrenia in cultural terms but am only pointing to the inconclusive and unsatisfactory character of the relativistic personality deviation conceptions.

Then too, the attempt to type cultures in terms of some dominant theme may have a limited usefulness but it has also led to unreasonable applications. Questions appearing during the last two decades such as, "Is Germany suffering from paranoia?" or "Does England have a senile psychosis?" explain nothing but only add to the intellectual confusion of our times.⁵⁰ A conception such as the above would have significance only to the extent that it could be shown that this dominant cultural theme is reflected in the personalities of a large majority of the persons in the society. Even then one is still faced with the problem of who is likely to be regarded as paranoid in a "paranoid" culture.

On the positive side these studies have certainly brought about a working research relationship between psychoanalysis and cultural anthropology. They have stimulated the growth of neo-freudianism with their acceptance of a restatement of the relationship of the individual and society and personality and culture. While this restatement succeeds in incorporating into psychoanalysis the anthropologically empirically derived conception of culture, it has not succeeded in forming a very satisfactory sociological foundation for the emergence of a dynamic psychology of the personality.

CASTE AND CLASS STUDIES

The development of the caste-class framework for purposes of social analysis is peculiarly the work of W. L. Warner,⁵¹ his co-workers and students. True, the class aspect of human society had been portrayed by the first generation of sociologists in the United States but it was not until the fourth decade of the twentieth century that the class concept became a heuristic tool in American sociology.

⁵⁰ Franz Alexander, "Psychoanalysis and Social Disorganization," *American Journal of Sociology*, 42 (May, 1937), 781-813.

⁵¹ W. L. Warner, "American Caste and Class," *American Journal of Sociology*, 42 (September, 1936), 234-237.

The studies which have been reported on by Warner and his students while in most instances not dealing with the socially recognized more abnormal types of human adjustment deserve mention here because of their concern with (1) the nature of human socialization through specific forms of child training (2) the attempt to show the differentiating role of class in the personality structure developed.⁵²

The studies in this group have provided a framework within which personality disorders of our society might be studied. Using his class schema, Warner pointed to three ways of regarding the development of mental disorders.⁵³ He saw these afflictions as a result of (1) changes in social organization produced by technology, (2) the breaking up of institutional symbolic systems, and (3) frustration arising in the person when his vertical mobility was blocked. These three ideas are hardly new and bear a close resemblance to the cultural lag theory, Durkheim's notion of anomie, and Horney's emphasis on the competitive struggle and its role in the genesis of neuroses.

Green, using the class concept, attempts to show the kind of middle class family situation leading to neurosis and the kind of middle class family situation which does not. In the Polish middle class family he finds that the child does not become neurotic because the family does not absorb his personality, while in the American middle class family of several generations the child does become neurotic because as an object of ambivalent parental feelings he is a threat to the social life and career goals of the parents.⁵⁴ Ericson on the basis of interviews with samples of lower class and middle class mothers concludes "that membership in a social class is an important influence on personality development and that there are significant differences in child-rearing practices between social classes."⁵⁵

These studies are pretty much analogous to the personality-

⁵² See A. Davis, and John Dollard, *Children of Bondage*, Washington, D.C., American Council on Education, 1940. See also the other studies of the American Council on Education on the personality development of Negro Youth.

⁵³ W. L. Warner, "The Society, the Individual and his Mental Disorders," *American Journal of Psychiatry*, 94, 275-284.

⁵⁴ A. W. Green, "The Middle-Class Male Child and Neurosis," *American Sociological Review*, II (February, 1946), 31-41. (No. 23 in this volume.)

⁵⁵ Martha C. Ericson, "Child Rearing and Social Status," *American Journal of Sociology*, 52 (November, 1946), 190-192.

culture studies, especially in their emphasis on child training. They, to date, have thrown little light on personality disorders, although they have been quick to show certain abnormal traits, and distorted attitudes as they are nurtured within a social class context. They may eventually prove significant by virtue of calling attention to the class character of some of our personality disorders. Future research utilizing these conceptual tools will produce a more adequate evaluation with respect to clarifying their worth in adding to knowledge of both normal and abnormal personalities.

STUDIES OF INTERPERSONAL RELATIONS

Finally, we come to a consideration of the kind of knowledge which has evolved through the careful scrutiny of various kinds of interpersonal relations and their consequences for personality organization. The studies and theory of this section fall appropriately into the following categories: (1) personality organization, (2) social interactional relationships, (3) behavioral consequences, and (4) sociometric developments.

PERSONALITY ORGANIZATION

This particular area is typified by Dai's descriptive and analytic account of the patient as a person.⁶⁶ True, its results are nothing more than working hypotheses, but it does succeed in pointing to the limitations of biology in dealing with the person and the possible integrations of psychoanalysis and sociology for psychiatry. Most significant is Dai's attempt to classify the possible social etiologies of various personality disorders. In a later paper, Dai attempts to show with reference to the frequencies of various psychoses found among patients admitted to the Peking Municipal Psychopathic Hospital that personality problems are essentially problems of social adjustment and are most easily understood in terms of the analysis of the person's conception of himself.⁶⁷

Dunham's descriptive and analytic account of the social personality of the catatonic⁶⁸ supplements and reinforces Dai's analy-

⁶⁶ Bingham Dai, "The Patient as a Person," in *Social and Psychological Studies in Neuro-Psychiatry in China*, Peking, 1939, pp. 1-30.

⁶⁷ Bingham Dai, "Personality Problems in Chinese Culture," *American Sociological Review*, 6 (October, 1941), 686-696.

⁶⁸ H. Warren Dunham, "The Social Personality of the Catatonic-Schizophrenic," *The American Journal of Sociology*, XLIX (May, 1944), 508-518.

sis. Here, the trait organization of the catatonic is depicted as being at a variance with the trait organization of the other young men in the community. This situation conditions all of the catatonic's interpersonal relations and consequently he has no way of getting an adequate conception of himself through interaction with others.

Along this same line is Faris' attempt to show the schizophrenic personality as a product of social isolation. Breaks in the communication and socialization processes lead to the trait of seclusiveness which in turn causes the person to withdraw further from society. The final result is the schizophrenic breakdown. Faris' subsequent report of a schizophrenic case implies the process of the building up of a unique world not shared by other persons.⁵⁹

SOCIAL INTERACTIONAL RELATIONSHIPS

Slotkin studied the nature and effects of social interaction among a group of schizophrenics.⁶⁰ His main conclusion was that, since symbolic interaction is largely absent among schizophrenes because of the private character of the symbolism, then normal symbolic interaction is basic to the development of society and culture.

Rowland has studied the nature of the social process within the mental hospital and the kinds of friendship patterns which develop between patient-employee and patient-patient as a consequence of the interactional process.⁶¹ Dunham and Weinberg in a recent study⁶² have continued these interests showing the kind of cultural organization which develops among patients and employees in a state mental hospital and the impact of these two structures upon the patient, especially as it affects his length of stay in the hospital. Finally, Mangus and Seeley give us a kind of psychiatric *Middletown* in their attempt to discover the results of the abnormal

⁵⁹ See Robert E. L. Faris, "Cultural Isolation and the Schizophrenic Personality," *American Journal of Sociology*, 39 (September, 1934), 155-169; also his "Reflections of Social Disorganization in the Behavior of a Schizophrenic Patient," *American Journal of Sociology*, L (September, 1944), 134-141. (No. 17 in this volume.)

⁶⁰ J. S. Slotkin, "The Nature and Effects of Social Interaction in Schizophrenia," *The Journal of Abnormal and Social Psychology*, 37 (June, 1942), 345-368.

⁶¹ See Howard Rowland, "Interaction Processes in the State Mental Hospital," *Psychiatry*, I (August, 1938), 323-337. also "Friendship Patterns in the State Mental Hospital," *ibid.*, 2 (August, 1939), 363-373.

⁶² H. Warren Dunham and Kirson Weinberg, "Social Psychological Study of a Mental Hospital" (Unpublished Manuscript), 1947.

social interactional currents and the twisted interpersonal relations in a rural community.⁶³

Lindesmith depends on the process of communication for the making of drug addicts. He is successful in showing that explanations of drug addicts in terms of psychopathy are inadequate and do not fit the facts. Drug addiction, as Lindesmith demonstrates, is thus social through and through; it evolves within a social process.⁶⁴

BEHAVIORAL CONSEQUENCES

Thorner shows that the pattern of ascetic protestantism accounts for the basic personality structure of the middle class family and subsequently for much of the denial of affection with resulting frustration.⁶⁵

Dunham's study of criminal behavior among schizophrenes succeeded in making the differentiation between criminal behavior of so-called normals and criminal behavior of schizophrenics and in pointing to the conditions necessary for criminal behavior to appear in the schizophrenic.⁶⁶

Weinberg is able to show using data of neuroses arising in combat that "neurotic-like reactions may emerge among stable personalities when the experiences are sufficiently critical."⁶⁷ Through analysis of case materials, Taylor finds that apparently normal adjustment in only children is related to the emergence of neurasthenic symptoms.⁶⁸ Davis, attempting to examine by one case the consequence of social isolation, concludes that an absence of speech, inability to walk, no sense of gesture, complete inability to care for

⁶³ See A. R. Mangus and John R. Seeley, *Mental Health Needs in a Rural and Semi-Rural Area of Ohio*, Mimeographed Bulletin No. 195, Department of Rural Economics and Rural Sociology, Ohio State University, Columbus, Ohio, January, 1947. (No. 13 in this volume.)

⁶⁴ See A. R. Lindesmith, "A Sociological Theory of Drug Addiction," *American Journal of Sociology*, 48 (January, 1938), 593-609, also his "The Drug Addict as a Psychopath," *American Sociological Review*, 5 (December, 1940), 914-920.

⁶⁵ Isidor Thorner, "Sociological Aspects of Affectional Frustration," *Psychiatry*, VI (May, 1943), 157-173.

⁶⁶ H. Warren Dunham, "The Schizophrenic and Criminal Behavior," *American Sociological Review*, 4 (June, 1939), 352-366.

⁶⁷ S. Kirson Weinberg, "The Combat Neuroses," *American Journal of Sociology*, XI (March, 1946), 465-478.

⁶⁸ Louis Taylor, "The Social Adjustment of the Only Child," *American Journal of Sociology*, LI (November, 1945), 227-232.

self, adds support to the Mead-Cooley theory of socialization. In a final note, Davis concludes that Anna is not the most ideal case for showing the effect of isolation as she was probably deficient from the beginning.⁶⁹ Finally, Devereux offers a hypothetical sociological explanation of schizophrenia by stating that it is a consequence of the failure of a person to make the correct extrapolations from a new environment to which he moves or drifts.⁷⁰

SOCIOMETRIC DEVELOPMENTS

The point of view, researches, and system of therapy developed by Moreno⁷¹ deserve mention here because of their current contemporary influence in sociological circles.⁷² The point of view represented here is found in the social psychology of Mead and Cooley and is partially developed in psychiatry through the writings of Harry Stack Sullivan. The procedure of charting the frequency and intensity of interpersonal relations in any group is a valuable technique for showing certain aspects of the relations which actually take place in the group. Moreno and his associates have thus provided the student of interpersonal relations with a tool for the study of personality deviation as it appears to emerge in a group context.⁷³

This technique lays an empirical basis for viewing interpersonal relations and serves as a substitute for the descriptions of group life and process which have appeared in the theoretical literature. The therapy of psychodrama, where the person either acts out his inner psychological role alone or with other "auxiliary egos" again

⁶⁹ See Kingsley Davis, "Extreme Social Isolation of a Child," *American Journal of Sociology*, XLV (January, 1940), 554-656, also his "Final Note on a Case of Extreme Isolation," *American Journal of Sociology*, LII (March, 1947), 432-437.

⁷⁰ George Devereux, "A Sociological Theory of Schizophrenia," *Psychoanalytic Review*, 26 (June, 1939), 315-342.

⁷¹ J. L. Moreno, *Who Shall Survive*, Washington, D.C.: Nervous and Mental Disease Publishing Company, 1934.

⁷² We have included Moreno in our appraisal even though well aware of the fact that professionally he can be regarded as a psychiatrist rather than a sociologist and our attempt has been to see "social psychiatry" as it has developed in the hands of sociologists. However, we feel justified inasmuch as the sociologists and psychologists have largely supported Moreno's research and therapy. The editorial board of *Sociometry* includes twelve recognized sociologists, about fifty per cent of the total.

⁷³ See his "Interpersonal Therapy and the Psychopathology of Interpersonal Relations," *Sociometry*, 1 (1937), 9-76.

throws Mead's role-taking scheme either of the self-other or generalized-other variety on the stage, and the person depicts his conflicts and tensions as they may exist in the reality situation. Thus, this role-taking therapy is a partial demonstration of Mead's theory and also provides the earliest sociograms for charting the interpersonal relations within a situational context. From the stage to the sociometric study of the real life situation is a short step for which Moreno has provided an elaborate scheme of new concepts, such as the tele, aristotele, social atom and sociometric assignment. Neuroses and maladjustments are products of interpersonal situations arising in group life. The therapeutic scheme developed and the tool for measuring interpersonal relations are devices which should serve to make for a more sophisticated statement of symbolic-interactional psychology.

The studies reported, in this section, while at first glance they seem unrelated, can, as we have shown, be classified in a general way. The field is new and largely unexplored from an empirical perspective. These studies and others like them should eventually form the foundation for getting research workers closer to the significant problems, which for the most part, we must learn to formulate. This is perhaps no more clearly demonstrated than in the instance of trying to study the "self." The nature and origin of the self is the core of much social psychology, but this social entity cannot be chiseled out in a definitive fashion until we can develop more satisfactory techniques for observing it develop and watching it change. Such descriptive terms as the distorted self, the guilty self, the wounded self, the projective self, the destructive self and the like are suggestive of the social psychological results evolving from family or other group interpersonal relation, but knowledge about these things will continue to elude us until we can show more conclusively the processes of interpersonal relations which bring about such results. This implies the necessity to develop some better techniques for exploring the psychological character of various kinds of structured relationships from the pair to the complex institution, and to show the manner in which these social entities may be related to the genesis of the self and to the distortion of the self at any stage in its development, fixation or regression. In attacking the problems implied here, it seems not out of place to point out that we need to bring about a fusion of those elements which may prove valid for both symbolic interactional and psychoanalytic psychology.

THE CURRENT SITUATION

In this paper we have, thus, tried to do two things. First, we have attempted to show the dubious character of social psychiatry as a special field of sociology and to point to the emergence of a set of problems centering around the personality problems of man in society, the answers to which many different disciplines will contribute. Secondly, we have tried to point out and critically evaluate the various kinds of researches carried on by sociologists and anthropologists during the past fifteen years which have been regarded, at least by sociologists, as constituting the field of social psychiatry.

With respect to our first point, we can only wait for time to give the answer, although in accordance with the trends in education and the scientific literature we feel vaguely that we have pointed to what will eventually emerge.

With respect to the research developments during the period under consideration, it seems to the writer that such researches have been far more valuable in evolving new techniques, viewpoints, and hypotheses, and much less significant when it comes to a conclusive demonstration of the exact relationships between personality disorders and some element of interpersonal relations or of cultural situations. We cannot be content continually with offering "supporting" and "inferential" evidence, especially if we continue to adhere to the hypothetical proposition that many personality disorders have their roots in the social milieu.

In a very positive sense all of these studies upon which we have reported have served to bring about a closer working relationship between the various disciplines. In this process, as we have shown, there has been a gradual coming together of certain psychoanalysts, psychiatrists, anthropologists, psychologists, and sociologists in their interests so that gradually they are focusing their attention on certain common problems: the self, cultural influences on the personality, the nature of these influences as personal experience, the differentiation of influences at different societal levels, the nature of interpersonal involvements and cultural or unique character of child training practices—these are the problems which must continue to receive attention if satisfactory answers are forthcoming.

Four specific problem areas need some exploration and may

throw light upon some of the generally stated problems above. I think there is an immediate need for an elaborate follow-up study of patients of different types who are discharged from mental hospitals. We need to know what happens to them, the kind of adjustments they make, their relationships with others and the like. Such a concrete picture might not only be suggestive with respect to etiological theories, but it might also be useful for therapeutic programs. Another problem demanding attention is to explore the nature of contrasting "family psychologies" in our society as well as other societies. Certain families in the interaction of their members succeed in creating psychological atmospheres which have adverse personality consequences.

There is also the need for a sociological study of the mentally disturbed child, the schizophrenic child, and the kind of social situation in which he is nurtured. Such study may focus attention upon the kinds of experience likely to be damaging to the self as it emerges.⁷⁴

Finally, it seems to me we need to return to an older emphasis in sociology and repeat many institutional studies by means of the new techniques which have been developed in sociometry, psychoanalysis and social psychology. Such studies should put us in a position of seeing the kinds of interpersonal relations within a given structure to which persons are subjected and give us some valid picture of the psychological atmosphere which is created. In this way we could see how an institutional structure fosters already existing fears, anxieties and insecurities of the person and develops new ones. Such studies should prove valuable not only in showing us the impact of certain interpersonal relations and psychological climates on the person, but also for showing how certain kinds of maladjusted and neurotic persons are frequently permitted to obtain positions of authority and then use their office in the institution to literally inflict their neuroses upon others.

In this area of research endeavor as in other social science areas our big and most significant task is to formulate the correct statement of our problems. This is crucial in all research but as we all know especially difficult in social science research. If we can do this, the techniques for solving these problems can be evolved. When psychiatry as a branch of medicine departs in its research

⁷⁴ For an account of such cases, seen within a clinical psychiatric framework, see Charles Bradley, *Schizophrenia in Childhood*, New York, The Macmillan Co., 1941.

from the traditional clinical biological and physiological orientation it faces the same methodological problems as does sociology. This has been happening, as we have shown, during the last two decades and so in the future, we can expect progress in this area to the extent that significant questions can be raised and that the significance of these questions can be agreed upon by the various scientific disciplines concerned. In this way, we will move toward a meaningful "social psychiatry."

SECTION II

Social Characteristics of the Mentally Disordered

FIVE

Summary of Studies on the Incidence of Mental Disorders *

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THE FOLLOWING tables represent an attempt to give a systematic summary of the findings reported in published researches dealing with mental disorders as related to various social variables. We have used all those social variables for the categories of which the incidence of mental disorder has been reported in three or more studies. We have tried to cover the relevant literature in English (reporting studies written in a foreign language only when they have been summarized in some English-language publication), but no doubt have missed some sources due to inadequacies in our library facilities or in our searching abilities. We have deliberately eschewed evaluation, reporting studies of little value alongside those of great generalizability. Questions concerning the reliability, generalizability, and consistency of the findings are left to the reader for evaluation.

With regard to the data published by the United States government, on mental disorders reported for the various states and the nation as a whole, only the most recent report has been utilized

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in this summary, namely *Patients in Mental Institutions in 1949*. The federal government has published an annual census of patients in mental institutions since 1923.¹

The style of presentation of the tables varies. Some items are given in the form of a summary statement, others by a listing of rates or percentages. Unless otherwise specified, all rates are based on first admissions per 100,000 population, standardized by age (whenever necessary, figures have been rounded to one decimal place). The tables are organized in terms of the social variables, with subclassifications for each of the types of mental disorder for which data are available. Each item, in addition to reporting the finding in the form of a comparison, indicates the area and time period covered in the study. Sources are indicated by means of two figures in parentheses: the first represents the number of the item in the bibliography listed at the end of the tables, and the second figure represents the relevant page numbers in this source. Where specific figures are not available, a dash substitutes for the missing figures.

TABLE 1. AGE, SEX, AND MENTAL DISORDER †

ALL MENTAL DISORDERS

Highest incidence at age: males 80-89, females 80-89; total 80-89. Males had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Highest incidence at age: males 75+, females 75+; total 75+. Males had highest incidence.—State mental hospitals in the U.S.A., 1933. (32:163)

Highest incidence at age: males 80+, females 80+; total 80+. Males had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:70)

Average age: males 48, females 45; total 47.—All state and licensed mental institutions in New York State, 1943-44. (36:281-83)

¹ Since 1947 these have been conducted by the National Institute of Mental Health. Prior to that time the census was under the auspices of the Bureau of the Census. The Bureau of the Census has collected data on persons with mental disorders since 1840, but it was not until 1923 that annual reports were compiled and published. These annual publications contain data on first admissions by age, sex, and type of mental disorder for mental patients in state hospitals. In recent years the coverage has been expanded to include data on county, city, and private hospitals as well. These reports vary considerably in the presentation of data. Before 1947 a substantial number of rates were calculated and included, but since that time the reports contain primarily raw data.

Highest incidence at age: males and females 75+. Males had highest incidence for all three periods.—All state and licensed hospitals for mental disease, New York, 1919-21, 1929-31, 1939-41. (45:344-66)

Highest incidence at age: male and female 65+. Males had highest incidence.—State mental hospitals in twelve states,* 1919. (15:597)

Highest incidence at age: males 80+, females 80+. Males had highest incidence.—Illinois mental hospitals, 1922-24, 1929-31. (10:1991-2004)

Highest incidence at age: males 65-74, females 45-54, total 65-74. Females had highest incidence.—Mental hospitals in England and Wales, 1932. (58:180)

Highest incidence at age: males and females 70+. Males had highest incidence.—Canadian mental institutions, 1932-47. (11:336-45)

Highest incidence at age: males and females 70+. Males had highest incidence.—All institutions for mental disease in New York State, 1940-41. (60:403)

Median age: males 47.2, females 46.6; total 46.9. Males had highest incidence.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

ALL PSYCHOSES

Incidence by sex: males exceed females.—State mental hospitals in the U.S.A., 1933. (32:40)

Median age: males 51.6, females 49.0; total 50.3.—State Hospitals for mental disease in the U.S.A., 1949. (63:39-41)

SCHIZOPHRENIA

Highest incidence at age: males 20-29, females 30-39; total 20-29. Males had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Highest incidence at age: males 20-24, females 35-39; total 25-29. Males had highest incidence.—State mental hospitals in the U.S.A., 1933. (32:40, 163)

Highest incidence at age: males 20-24, females 35-39; total 25-29. Males had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:80)

Median age: males 29, females 33; total 31.—Cleveland State Hospital, 1928-37. (22:5)

Highest incidence at age: males 25-29, females 35-39 (1919-21); males 20-24, females 25-29 (1939-41). Males had highest incidence.—All state and licensed hospitals for mental disease in New York State. (45:358)

Median age: males 31.6, females 33.3; total 32.6.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Median age: males 28.9, females 34.4 (whites only). Females had highest incidence.—Georgia State Hospital, 1923-32. (24:32-33)

TABLE 1 (continued)

Highest incidence at age: males 25-29, females 25-29. Males had highest incidence.—New York civil state hospitals, 1912-18. (51:598)

Highest incidence at age: males 20-24, females 25-34. Females had highest incidence.—Mental hospitals in England and Wales, 1932. (58:180)

Age at onset of disease: males 21-25, females 26-30.—All mental hospitals in Norway, 1926-35. (46:397)

Highest incidence at age: males and females 25-39.—Selected mental hospitals in New Jersey, 1944-46. (12:461)

Highest incidence at age: males 25-29, females 30-34. Females had highest incidence. Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889-1929. (47:97-99)

Average age: males and females 30. Virginia State Hospital, 1940-51. (33:113)

Median age: males 32.7, females 33.3 (employed persons only).—State mental hospitals in Ohio, 1950. (13:149, 151)

MANIC DEPRESSIVE

Highest incidence at age: males 50-59, females 30-39; total 50-59. Females had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Highest incidence at age: males 50-54, females 45-49; total 45-49. Females had highest incidence.—State mental hospitals in the U.S.A., 1933. (32:40, 163)

Highest incidence at age: males 40-44, females 35-39, total 35-39. Females had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:78)

Median age; males 43, females 43; total 43.—Cleveland State Hospital, 1928-37. (22:5)

Highest incidence at age: males 25-29, females 35-39 (1919-21); males 45-49, females 35-39 (1939-41). Females had highest incidence.—All state and licensed hospitals for mental disease in New York State. (45:357)

Median age: males 44.4, females 39.4; total 41.3.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Median age: males 35.9, females 37.7 (whites only). Females had highest incidence.—Georgia State Hospital, 1923-32. (24:32-33)

Age at first attack: males 36-40, females 26-30; total 26-30.—Based on 633 cases from a private practice in Chicago, no date. (50:157-58)

Highest incidence at age: males 55-64, females 45-54. Females had highest incidence.—Mental hospitals in England and Wales, 1932. (58:180)

Age at onset of disease: males 46-50, females 51-55.—All mental hospitals in Norway, 1926-35. (46:397)

Highest incidence at age: males and females 25-39.—Selected mental hospitals in New Jersey, 1944-46. (12:461)

Highest incidence at age: males 55-59, females 45-49; total 45-49. Females had highest incidence.—Hospitals for mental disease in the U.S.A., 1922. (52:658)

Median age: males 45.8, females 42.5 (employed persons only).—State mental hospitals in Ohio, 1950. (13:149, 151)

INVOLUTIONAL PSYCHOSES

Highest incidence at age: males 50-59, females 40-49; total 50-59. Females had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Highest incidence at age: males 55-59, females 50-54; total 50-54. Females had highest incidence.—State mental hospitals in the U.S.A., 1933. (32:40, 163)

Average age: males 55, females 52; total 53. Females had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:53-54)

Median age: males 52, females 47; total 47. Cleveland State Hospital, 1928-37. (22:5)

Highest incidence at age: males and females 40+. Selected mental hospitals in New Jersey, 1944-46. (12:461)

Median age: males 58.6, females 51.0 (employed persons only). State mental hospitals in Ohio, 1950. (13:149, 151)

Median age: males 56.4, females 51.8; total 53.1.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Highest incidence at age: males and females 50-54. Females had highest incidence.—All hospitals in New York State, 1942. (31:19)

PARANOIA

Highest incidence at age: males 50-59, females 50-59; total 50-59. Females had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Incidence by sex: males exceed females.—State mental hospitals in the U.S.A., 1933. (32:40)

Average age: males 50, females 50; total 50. Females had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:53-54)

Median age: males 46, females 46; total 46.—Cleveland State Hospital, 1928-37. (22:5)

Highest incidence at age: males and females 40+.—Selected mental hospitals in New Jersey, 1944-46. (12:461)

Highest incidence at age: males 35-44, females 45-54. Females had

TABLE 1 (continued)

highest incidence.—Mental hospitals in England and Wales, 1932. (58:180)

Median age: males 48.4, females 50.0; total 49.0.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

SENILE PSYCHOSES

Highest incidence at age: males 90+, females 90+. Females had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Incidence by sex: males exceed females.—State mental hospitals in the U.S.A., 1933. (32:40)

Highest incidence at age: males 80+, females 80+. Females had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:72)

Median age: males 72, females 69; total 71.—Cleveland State Hospital, 1928-37. (22:5)

Highest incidence at age: males and females 75+. Females had highest incidence.—All state and licensed hospitals for mental disease in New York State, 1919-21, 1939-41. (45:350-51)

Age at onset of disease: males 71-75, females 71-75.—All mental hospitals in Norway, 1926-35. (46:397)

Highest incidence at age: males and females 75+. Females had highest incidence.—Mental hospitals in England and Wales, 1932. (58:180)

Median age: males 65+, females 65+ (employed persons only).—State mental hospitals in Ohio, 1950. (13:149, 151)

Median age: males and females 70+.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Median age: males 69.8, females 69.6 (whites only). Females had highest incidence.—Georgia State Hospital, 1923-32. (24:32-33)

Highest incidence at age: males and females 70+. Females had highest incidence.—All hospitals in New York State, 1942. (31:15)

GENERAL PARESIS

Highest incidence at age: males 40-49, females 40-49; total 40-49. Males had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Highest incidence at age: males 45-49, females 50-54; total 45-49. Males had highest incidence.—State mental hospitals in the U.S.A., 1933. (32:40, 163)

Highest incidence at age: males 45-49, females 40-44; total 40-44. Males had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:74)

Highest incidence at age: males 40-44, females 40-44 (1919-21); males 50-54, females 40-44 (1939-41). Males had highest incidence.—All state and licensed hospitals for mental disease in New York State. (45:354)

Age at onset of disease: males 46-50, females 41-45.—All mental hospitals in Norway, 1926-35. (46:397)

Median age: males 47.6, females 45.8; total 47.2.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Highest incidence at age: males 35-44, females 45-54. Males had highest incidence.—Mental hospitals in England and Wales, 1932. (58:180)

Highest incidence at age: males and females 35-39. Males had highest incidence.—Eighty-eight state mental hospitals in the U.S.A., 1921. (14:566)

Median age: males 42.9, females 38.9 (whites only). Males had highest incidence.—Georgia State Hospital, 1923-32. (24:32-33)

CEREBRAL ARTERIOSCLEROSIS

Highest incidence at age: males 80-89, females 80-89; total 80-89. Males had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Incidence by sex: males exceed females.—State mental hospitals in the U.S.A., 1933. (32:40)

Highest incidence at age: males 75-79, females 75-79; total 80+ . Males had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:72)

Median age: males 63, females 62; total 63.—Cleveland State Hospital, 1928-37. (22:5)

Median age: males 65+, females 65+ (employed persons only).—State mental hospitals in Ohio, 1950. (13:149, 151)

Median age: males and females 70+.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Highest incidence at age: males 65-69, females 75+ (1919-21); males 75+, females 75+ (1939-41). Males had highest incidence.—All state and licensed hospitals for mental disease in New York State. (45:352)

Median age: males 65.2, females 65.8 (whites only). Males had highest incidence.—Georgia State Hospital, 1923-32. (24:32-33)

Highest incidence at age: males and females 70+ . Males had highest incidence.—All hospitals in New York State, 1942. (31-16)

ALCOHOLIC PSYCHOSES

Highest incidence at age: males 40-49, females 40-49; total 40-49. Males had highest incidence.—Massachusetts state mental hospitals, 1917-33. (9:464-65)

Highest incidence at age: males 45-49, females 40-44; total 45-49. Males had highest incidence.—State mental hospitals in the U.S.A., 1933. (32:40, 163)

Highest incidence at age: males 45-49, females 40-44; total 45-49. Males had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:76)

TABLE 1 (continued)

Median age: males 43, females 41; total 42.—Cleveland State Hospital, 1928-37. (22:5)

Median age: males 44.0, females 46.6 (employed persons only).—State mental hospitals in Ohio, 1950. (13:149, 151)

Median age: males 45.8, females 42.5; total 45.2.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

Highest incidence at age: males 55-59, females 45-49 (1919-21); males 45-49, females 50-54 (1939-41). Males had highest incidence.—All state and licensed hospitals for mental disease in New York State. (45:355)

Average age: males 48, females 46. Males had highest incidence.—All hospitals for mental disease in New York State, 1947-48. (38:464)

Highest incidence at age: males 55-59.—Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889-1929. (47:97)

PSYCHONEUROSES

Highest incidence at age: males 30-39, females 30-39; total 30-39. Females had highest incidence.—Massachusetts state mental hospital, 1917-33. (9:464-65)

Incidence by sex: females exceed males.—State mental hospitals in the U.S.A., 1933. (32:40)

Average age: males 36, females 37; total 36. Females had highest incidence.—All institutions for mental disease in New York State, 1929-31. (44:53-54)

Median age: males 32.5, females 39.2 (employed persons only).—State mental hospitals in Ohio, 1950. (13:149, 151)

Median age: males 37.5, females 36.1; total 36.6.—State hospitals for mental disease in the U.S.A., 1949. (63:39-41)

TABLE 2. MENTAL DISORDER AND MARITAL STATUS

ALL MENTAL DISORDERS

Rates: Single males 131.6, females 86.7, total 111.3; married males 82.6, females 72.6, total 77.7; widowed males 294.5, females 168.6, total 203.1; divorced males 330.1, females 244.0, total 280.1.—All institutions for mental disease in New York State, 1929-31. (44:116-121)

Rates: Single males 221, females 130; married males 73, females 59;

† Unless otherwise specified all of the data contained in this table are based on first admissions.

* Arizona, Colorado, Iowa, Maine, Massachusetts, Nebraska, New Hampshire, New York, Rhode Island, South Carolina, South Dakota, Virginia.

widowed males 161, females 92; divorced males 362, females 263.—State mental hospitals in the U.S.A., 1933. (32:69)

Rates per 10,000 population by marital status at onset of mental illness (whites): married males 14.9, females 6.4; single males 14.1, females 4.5; separated males 30.2, females 12.1; widowed males 20.7, females 11.3; divorced males 96.0, females 64.3.—First admissions from Jefferson County to Arkansas State Hospital, 1930-38. (1:189)

Rates per 10,000 population: married 8.5, single 12.6, separated 17.9, widowed 30.4, divorced 37.8.—California state mental hospitals, 1945. (1:186)

Incidence of insanity higher among single, widowed, and divorced persons than among married people. Indicates that alcoholism and syphilis do not explain the variation.—First admissions to New Jersey State Hospital, Greystone Park, N.J., 1896-1930.† (18:368, 370)

Rates: Single 541, married 371, widowed 983, divorced 1,318.—New York mental hospitals, 1928-32. Single 552, married 378, widowed 985, divorced 1,482.—Massachusetts mental hospitals, 1928-32. (8:154)

Per cent distribution: Single males 75.0, females 43.2; married males 20.3, females 44.4; widowed males 2.1, females 7.7; separated males 1.1, females 2.3; divorced males 1.5, females 2.5.—First admissions to New York State hospitals, 1911-18. (16:293)

Married persons have the lowest incidence, followed by widowed, single, and divorced.—Admissions to Massachusetts mental hospitals (89,190 cases), 1917-33. (9:203)

Rates: Single males 1,138, married 449; single females 1,094, married 489 (ages 20-89). Married males 490, widowed 675, divorced 1,780; married females 548, widowed 691, divorced 1,452 (ages 30-69).—Mental hospitals in Norway, 1931-45. (48a:776)

ALL PSYCHOSES

Rates: Single males 211.2, females 135.9, total 174.0; married males 71.9, females 72.3, total 72.4; widowed males 193.3, females 107.4, total 150.7; divorced males 284.6, females 294.1, total 296.8.—All institutions for mental disease in New York State, 1929-31. (44:124)

Per cent distribution: single males 46.3, females 31.4; married males 39.4, females 45.4; widowed males 9.5, females 18.3; separated males 1.5, females 1.8; divorced males 1.2, females 1.2.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

Rates: Single males 132.8, females 111.8; married males 48.3, females 52.5.—All mental hospitals in Norway, 1926-35. (48:37)

SCHIZOPHRENIA

Rates: Single males 64.9, females 46.9, total 55.4; married males 11.9, females 19.3, total 15.4; widowed males 43.3, females 26.1, total 34.4;

TABLE 2 (continued)

divorced males 49.0, females 54.6, total 51.3.—All institutions for mental disease in New York State, 1929-31. (44:128)

Per cent distribution: Single males 73.9, females 44.8; married males 20.3, females 43.2; widowed males 2.0, females 6.8; separated males 1.0, females 2.0; divorced males 0.6, females 1.5.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

Rates: Single males 71.7, females 57.5; married males 15.4, females 19.0.—All mental hospitals in Norway, 1926-35. (48:39)

Rates: Single males 534, married 124; single females 495, married 133 (ages 20-89). Married males 101, widowed 189, divorced 501; married females 137, widowed 159, divorced 486 (ages 30-69).—Mental hospitals in Norway, 1931-45. (48a:779)

ALCOHOLIC PSYCHOSES

Rates: Single males 29.2, females 1.4, total 15.4; married males 8.6, females 2.5, total 5.5; widowed males 33.5, females 4.9, total 19.3; divorced males 29.4, females 5.1, total 17.2.—All institutions for mental disease in New York State, 1929-31. (44:126)

Per cent distribution: Single males 44.4, females 11.5; married males 41.1, females 59.5; widowed males 8.7, females 24.4; separated males 2.1, females 3.1; divorced males 2.6, females 0.8.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

Rates: Single males 3.8, females 0.4; married males 2.4, females 0.3.—All mental hospitals in Norway, 1926-35. (48:39)

Per cent distribution: Single males 36.4, females 13.8, total 31.1; married males 38.8, females 50.9, total 41.6; widowed males 10.3, females 13.8, total 11.1; separated males 3.4, females 8.2, total 4.6.—First admissions to all state and licensed hospitals for mental disease in New York State, 1942-43. (36:28)

Incidence no greater for divorced and single persons than for married persons.—First admissions to New Jersey State Hospital, Grey-stone Park, N.J., 1896-1930.† (18:368-69)

MANIC DEPRESSIVE

Rates: Single males 15.3, females 19.5, total 17.2; married males 7.7, females 15.7, total 11.7; widowed males 24.3, females 15.1, total 19.5; divorced males 27.0, females 42.8, total 34.8.—All institutions for mental disease in New York State, 1929-31. (44:127)

Per cent distribution: Single males 45.8, females 28.5; married males 45.1, females 59.6; widowed males 4.8, females 8.5; separated males 1.5, females 1.5; divorced males 0.7, females 0.7.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

Rates: Single males 13.3, females 18.3; married males 5.9, females 12.0.—All mental hospitals in Norway, 1926-35. (48:39)

Rates: Single males 92, married 62; single females 121, married 91 (ages 20-89). Married males 86, widowed 123, divorced 101; married females 117, widowed 129, divorced 166 (ages 30-69).—Mental hospitals in Norway, 1931-45. (48a:779)

PSYCHONEUROSES

Rates: Single males 1.5, females 2.4, total 1.9; married males 1.3, females 2.1, total 1.7; widowed males 1.0, females 1.2, total 1.2; divorced males —, females 3.3, total 1.9.—All institutions for mental disease in New York State, 1929-31. (44:127)

Per cent distribution: Single males 50.5, females 37.0; married males 44.4, females 48.6; widowed males 2.0, females 9.2; separated males 1.0, females 2.9; divorced males 1.0, females 1.7.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

GENERAL PARESIS

Rates: Single males 25.8, females 1.9, total 13.8; married males 11.7, females 4.1, total 7.9; widowed males 32.6, females 8.7, total 20.5; divorced males 50.4, females 21.7, total 37.7.—All institutions for mental disease in New York State, 1929-31. (44:126)

Per cent distribution: Single males 26.2, females 16.3; married males 59.9, females 54.0; widowed males 7.9, females 19.0; separated males 2.2, females 3.8; divorced males 1.8, females 4.2.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

Incidence no greater for divorced and single persons than for married persons. First admissions to New Jersey State Hospital, Greystone Park, N.J., 1896-1930.† (18:368-69)

Rates: Single males 76, married 57; single females 19, married 24 (ages 20-89). Married males 77, widowed 102, divorced 278; married females 30, widowed 43, divorced 132 (ages 30-69).—Mental hospitals in Norway, 1931-45. (48a:779)

INVOLUTIONAL PSYCHOSES

Rates: Single males 1.0, females 2.5, total 1.7; married males 2.3, females 3.9, total 3.1; widowed males 4.2, females 6.2, total 5.6; divorced males 4.5, females 2.2, total 3.2.—All institutions for mental disease in New York State, 1929-31. (44:116-121)

Per cent distribution: Single males 21.1, females 17.9; married males 65.0, females 53.6; widowed males 11.4, females 24.5; separated males 1.6, females 1.8; divorced males 0.8, females 0.9.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

Rates: Single males 1.6, married 2.0, divorced or widowed 5.2; single females 2.6, married 5.1, divorced or widowed 8.0; total single 4.0,

TABLE 2 (continued)

married 7.1, divorced or widowed 13.1.—Ohio State mental hospitals, 1951-52. (13a:243)

PARANOIA

Rates: Single males 0.8, females 1.3, total 1.0; married males 0.9, females 0.6, total 0.8; widowed males 1.5, females 2.0, total 1.9; divorced males 3.0, females 10.9, total 7.6.—All institutions for mental disease in New York State, 1929-31. (44:116-21)

Per cent distribution: Single males 35.7, females 25.7; married males 48.4, females 46.4; widowed males 6.3, females 22.1; separated males 2.4, females 4.3; divorced males 3.2, females 0.7.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

SENILE PSYCHOSES

Rates: Single males 3.5, females 6.2, total 4.7; married males 5.0, females 3.2, total 4.1; widowed males 71.5, females 57.5, total 61.3; divorced males 9.0, females 9.8, total 9.5.—All institutions for mental disease in New York State, 1929-31. (44:116-21)

Per cent distribution: Single males 15.3, females 16.3; married males 44.2, females 23.2; widowed males 35.4, females 56.0; separated males 1.8, females 1.2; divorced males 1.3, females 1.0.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (3:379-80)

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Rates: Single males 88.2, females 49.6, total 70.4; married males 36.4, females 25.9, total 32.0; widowed males 74.6, females 42.5, total 59.6; divorced males 109.4, females 87.9, total 102.8.—All institutions for mental disease in New York State, 1929-31. (44:125)

Per cent distribution: Single males 14.2, females 16.9; married males 54.9, females 30.9; widowed males 25.7, females 47.9; separated males 1.9, females 1.3; divorced males 1.5, females —.—First admissions to forty-six state mental hospitals in twelve states,* 1919. (53:379-80)

* Arizona, Colorado, Iowa, Maine, Massachusetts, Nebraska, New Hampshire, New York, Rhode Island, South Carolina, South Dakota, Virginia.

† Data for divorced insane for 1906-1930 only.

‡ Term "insanity" used with no indication as to what it includes.

TABLE 3. MENTAL DISORDER AMONG URBAN AND RURAL POPULATIONS

ALL MENTAL DISORDERS

Rates: † Urban males 83.4, females 68.1, total 75.7; rural males 52.7, females 46.0, total 49.5.—New York civil state hospitals, 1929–31. Data include rates for major cities and for four classes of cities. (44:90)

Rates: Urban males 134.8, females 94.1, total 113.5; rural males 69.5, females 44.6, total 58.0.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 86.0, rural 41.4 (1910); urban 78.8, rural 41.1 (1922). Generally the larger the city, the higher the rates.—Public and private mental hospitals in U.S.A. (59:264–65)

Rates: † Urban 69.9, rural 37.9.—State hospitals in nine states,* 1919. (53:375)

ALL PSYCHOSES

Rates: Urban 58.4, rural 4.8.—Georgia State Hospital, 1923–32. (24:37)

Rates: Urban males 113.7, females 90.3, total 102.7; rural males 64.7, females 58.3, total 61.6.—New York civil state hospitals, 1929–31. (44:110)

SCHIZOPHRENIA

Rates: Urban males 29.1, females 25.3, total 27.0; rural males 15.1, females 14.7, total 14.8.—New York civil state hospitals, 1929–31. Data include rates for major cities and for four classes of cities. (44:110)

Rates: Urban males 14.5, females 14.1, total 14.2; rural males 8.1, females 6.8, total 7.4.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban males 21.4, females 19.1; rural males 9.0, females 10.6 (1920). Urban total 19.1, rural total 7.8 (1915–20).—New York civil state hospitals. (51: 601)

Relative percentage frequency: Minneapolis 61.0. minor cities 5.8, rural 33.2.—Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889–1929. (47:179)

Rates: † Urban 19.4, rural 9.5.—State hospitals in nine states,* 1919. (53:375)

ALCOHOLIC PSYCHOSES

Rates: Urban males 12.2, females 2.5, total 7.3; rural males 6.6, females 0.8, total 3.7.—New York civil state hospitals, 1929–31. Data includes rates for major cities and for four classes of cities. (44:110)

Rates: Urban males 10.0, females 1.7, total 5.9; rural males 3.1, females 0.2, total 1.7.—State hospitals in the U.S.A., 1933. (32:164)

TABLE 3 (continued)

Rates: † Urban 2.8, rural 0.6.—State hospitals in nine states,* 1919. (53:375)

Incidence much higher in urban than in rural areas.—First admissions to all state and licensed mental hospitals in New York State, 1944. (36:291)

Relative percentage frequency: Minneapolis 57.0, minor cities 3.0, rural 40.0.—Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889-1929. (47:179)

MANIC DEPRESSIVE

Rates: Urban males 10.0, females 15.7, total 12.8; rural males 8.1, females 12.1, total 10.0.—New York civil state hospitals, 1929-31. Data include rates for major cities and for four classes of cities. (44:110)

Rates: Urban males 8.4, females 10.6, total 9.5; rural males 7.3, females 7.4, total 7.4.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 10.5, rural 6.8.—State hospitals in nine states,* 1919. (53:375)

Rates: Urban males 6.9, females 12.3, total 9.6; rural males 4.9, females 8.3, total 6.6.—New York civil state hospitals, 1918-22. (52:662)

GENERAL PARESIS

Rates: Urban males 17.1, females 4.6, total 10.8; rural males 5.9, females 2.3, total 4.1.—New York civil state hospitals, 1929-31. Data include rates for major cities and for four classes of cities. (44:110)

Rates: Urban males 15.2, females 4.2, total 9.6; rural males 4.9, females 1.6, total 3.3.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 8.6, rural 2.0.—State hospitals in nine states,* 1919. (53:375)

Incidence much higher in urban than in rural areas.—Based on first admissions to all state and licensed hospitals for mental disease in New York State, 1944-45. Data include percentages for major cities and for four classes of cities. (37:227)

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Rates: Urban males 56.6, females 39.0, total 49.1; rural males 23.3, females 15.4, total 19.4.—New York civil state hospitals, 1929-31. Data include rates for major cities and for four classes of cities. (44:110)

Rates: Urban males 58.4, females 35.7, total 46.1; rural males 24.4, females 12.0, total 18.7.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 3.3, rural 1.4.—State hospitals in nine states,* 1919. (53:375)

Relative percentage frequency: Minneapolis 42.7, minor cities 4.3,

rural 53.0.—Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889–1929. (47:179)

Rates: Urban 93.9, rural 40.6.—New York civil state hospitals, 1942. (31:16)

INVOLUTIONAL PSYCHOSES

Rates: † Urban males 1.3, females 2.6, total 1.9; rural males 1.8, females 3.2, total 2.4.—New York civil state hospitals, 1929–31. (44:84, 86)

Rates: Urban males 2.5, females 4.6, total 3.4; rural males 1.5, females 2.3, total 1.8.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 2.1, rural 1.2.—State hospitals in nine states,* 1919. (53:375)

Rates: Urban males 1.8, females 4.2, total 3.0; rural males 1.0, females 2.9, total 1.9.—Ohio State mental hospitals, 1951–52. (13a:243)

PARANOIA

Rates: † Urban males 0.5, females 0.7, total 0.6; rural males 0.5, females 0.5, total 0.5.—New York civil state hospitals, 1929–31. (44:84, 86)

Rates: Urban males 1.8, females 1.9, total 1.9; rural males 0.9, females 0.7, total 0.8.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 1.1, rural 0.6.—State hospitals in nine states,* 1919. (53:375)

SENILE PSYCHOSES

Rates: Urban males 25.3, females 31.3, total 30.8; rural males 14.8, females 13.6, total 15.2.—New York civil state hospitals, 1929–31. Data include rates for major cities and for four classes of cities. (44:110)

Rates: Urban males 61.8, females 54.0, total 57.4; rural males 33.5, females 21.8, total 28.0.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 7.2, rural 5.4.—State hospitals in nine states,* 1919. (53:375)

Rates: Urban 47.6, rural 34.8.—New York civil state hospitals, 1942. (31:16)

PSYCHONEUROSES

Rates: † Urban males 1.0, females 1.5, total 1.3; rural males 0.9, females 1.8, total 1.3.—New York civil state hospitals, 1929–31. (44:84, 86)

Rates: Urban males 1.5, females 2.1, total 1.8; rural males 1.0, females 1.3, total 1.1.—State hospitals in the U.S.A., 1933. (32:164)

Rates: † Urban 1.1, rural 0.5.—State hospitals in nine states,* 1919. (53:375)

† Crude or unspecified type of rates (per 100,000 population).

* Colorado, Iowa, Maine, Nebraska, New York, Rhode Island, South Carolina, South Dakota, Virginia.

TABLE 4. MENTAL DISORDER AND SOCIO-ECONOMIC STATUS

ALL MENTAL DISORDERS

Negative relationship with economic level of community. Army rejections varied from 7.3% from the highest to 16.6% from poorest community.—Boston, 1941-42, 60,000 military selectees. Used six classes of community desirability.† (27:543-48)

No consistent relationship with economic status. First admissions to New York civil state hospitals, 1920-37. Economic classes used: dependent, marginal, comfortable. Data on cases which suffered loss of employment. No rates. (44:277-78)

Negative relationship between mean rental and commitment. First admissions to public and private hospitals from Chicago, 1922-34. (30:536-37)

Negative relationship with occupation (ranked by income, prestige, and socio-economic status). Used twelve occupational categories. Rates given.—First admissions to Ohio state mental hospitals, 1950. (13:21)

No consistent relationship with economic status. First admissions to forty-six state hospitals in twelve states,* 1919. Per cent in each class: dependent 13.9, marginal 68.5, comfortable 17.6. (15:596)

ALL PSYCHOSES

Negative relationship with occupation and prestige. Male first admissions to selected Chicago hospitals, 1922-34. Used sixteen income and prestige groups, 12,000 male cases. (4:433-40)

Positive relationship between factors such as: relief, unemployment, unfit housing.—Based on admissions to public and private hospitals (1,800 cases), Peoria, Ill., 1928-39. (56:44)

Negative relationship with income (whites). Based on a psychiatric survey in Baltimore, Eastern Health District, 1936. Five income classes used, and rates per 1,000 population given. (34:106)

SCHIZOPHRENIA

Negative relationship with social class, New Haven, Conn., 1950. Used psychiatric survey, five classes, and established a prevalence index. (25:163-69)

Negative relationship with social class. First admissions in Freiburg, Germany, 1906-1912—first admissions to New York civil state hospitals, 1909-17—first admissions to state hospitals in U.S.A., 1933. (62:167-75)

Negative relationship with occupation, income, and prestige. White male first admissions to selected Chicago hospitals, 1922-34. (6:325-30)

* Schizophrenics came from lowest economic level, and went down

economic scale prior to hospitalization. Selected Chicago mental hospitals, 1946. Used sample of approximately 200 paranoid schizophrenics, manics, and depressives. (57:70-71)

Incidence reported by occupational level: lowest trade, 2nd professional, 3rd skilled, 4th farmers, highest unskilled.—Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889-1929. (47:182)

Negative relationship with economic level. First admissions to three Kansas state hospitals, 1925-35. (17:612)

Negative relationship with measures of "favorability of living" for various city wards. Based on 305 male admissions to Worcester State Hospital from Worcester, Mass., 1931-50. (19:99)

MANIC DEPRESSIVE

Slight positive relationship with income and occupational prestige. Chicago, 1922-34. Used sixteen income and occupational prestige groups, 12,000 cases. (4:433-40)

Positive relationship with economic level. First admissions to three Kansas state hospitals, 1925-35. (17:612)

Both manics and depressives came from a higher economic level than schizophrenics (manics came from a higher level than depressives). Selected Chicago mental hospitals, 1946. Used sample of approximately 200 paranoid schizophrenics, manics, and depressives. (57:70-71)

Negative relationship with social class.† First admissions in Freiburg, Germany, 1906-12—first admissions to New York civil state hospitals, 1909-17—first admissions to state hospitals in the U.S.A., 1933. (62:167-75)

PSYCHONEUROSES

No consistent relationship with economic level of community. Boston, 1941-42, 60,000 military selectees. Used six classes of community desirability. (27:543-48) ‡

Positive relationship with occupational level. U.S.A. military draft registrants, Nov. 1943-Dec. 1943. Used seven occupational categories and gave rejection rates per 1,000 men examined. (54:1087)

Negative relationship with income for income range, relief to \$2,000. Above \$2,000, neurosis rate rises and does not conform to the above relationship (white adults).—Based on a psychiatric survey in Baltimore, Eastern Health District, 1936. Five income classes used, and rates per 1,000 population given. (34:118)

ALCOHOLIC PSYCHOSES

Negative relationship with occupation and prestige. First admissions (white) from Chicago to nearby mental hospitals, 1922-34. Used sixteen occupational categories. (5:39-41)

TABLE 4 (continued)

Incidence reported by occupational level: Lowest professional, 2nd trade, 3rd farming, 4th skilled, highest unskilled.—Norwegian-born immigrants in Minnesota, Rochester State Hospital District, 1889-1929. (47:182)

GENERAL PARESIS

Negative relationship with socio-economic level. Farmers had very low rate.—First admissions to three Kansas state hospitals, 1925-35. (17:613)

Negative relationship with economic level. First admissions to all state and licensed hospitals for mental disease in New York State, 1944-45. Gives per cent in categories: dependent, marginal, and comfortable. (37:223)

* Arizona, Colorado, Iowa, Maine, Massachusetts, Nebraska, New Hampshire, New York, Rhode Island, South Carolina, South Dakota, Virginia.

† Includes data on psychopathic personalities and chronic alcoholics.

‡ Not consistent for rural population (U.S.A., 1933).

TABLE 5. NATIVITY AND MENTAL DISORDER

ALL MENTAL DISORDERS

Rates: † Native-born males 87.5, females 70.5, total 78.8; foreign-born males 101.4, females 82.3, total 92.1.—All mental institutions in New York State, 1926-28. (41:392)

Rates for foreign-born exceed those for native-born.—First admissions to Massachusetts state mental hospitals, 1917-33. (9:80-81)

Rates: Native-born 50.1; foreign-born 118.7.—State mental hospitals in eleven states, 1919. (15:591)*

ALL PSYCHOSES

Rates: Native-born males 103.2, females 79.7, total 91.8; foreign-born males 120.1, females 95.7, total 108.8.—All mental institutions in New York State, 1929-31. (44:175)

SCHIZOPHRENIA

Rates: Native-born males 24.7, females 20.0, total 22.2; foreign-born males 37.4, females 28.7, total 32.8.—All mental institutions in New York State, 1929-31. (44:176)

Rates: † Native-born white males 14.0, females 10.5, total 12.2; foreign-

born white males 28.8, females 24.4, total 26.8.—Institutions for mental disease in the U.S.A., 1922. (51:604)

Percentage distribution: Native white of native parentage 18.8, native white of foreign or mixed parentage 30.8, foreign-born white 34.9.—State and private hospitals, Chicago, 1922–34. (10a:103)

MANIC DEPRESSIVE

Rates: Native-born males 10.4, females 14.7, total 12.5; foreign-born males 11.5, females 20.4, total 15.8.—All mental institutions in New York State, 1929–31. (44:176)

Rates: Native white males 6.5, females 11.5, total 9.0; foreign white males 8.5, females 15.9, total 12.1.—New York civil state hospitals, 1918–22. (52:662)

Rates: Native white of native parentage 8.8, native white of foreign or mixed parentage 5.4, foreign-born white 7.7.—State and private hospitals, Chicago, 1922–34. (10a:74)

SENILE PSYCHOSES

Rates: Native-born males 21.7, females 22.7, total 24.1; foreign-born males 25.0, females 33.5, total 32.2.—All mental institutions in New York State, 1929–31. (44:175)

Rates: Native white of native parentage 51.6, native white of foreign or mixed parentage 27.6, foreign-born white 41.3.—State and private hospitals, Chicago, 1922–34. (10a:137)

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Rates: Native-born males 44.8, females 28.1, total 37.4; foreign-born males 50.1, females 39.3, total 46.0.—All mental institutions in New York State, 1929–31. (44:175)

GENERAL PARESIS

Rates: native-born males 14.2, females 4.0, total 8.9; foreign-born males 16.2, females 3.6, total 9.8.—All mental institutions in New York State, 1929–31. (44:175)

Incidence is higher among the foreign-born whites, when compared to the native-born. First admissions to all state and licensed hospitals for mental disease in New York State, 1944–45. (37:228–29)

Rates: Native white of native parentage 11.8, native white of foreign or mixed parentage 8.5, foreign-born white 12.9.—State and private hospitals, Chicago, 1922–34. (10a:129)

ALCOHOLIC PSYCHOSES

Rates: Native-born white males 10.8, females 1.9, total 6.3; foreign-born males 11.4, females 2.1, total 6.7.—All mental institutions in New York State, 1929–31. (44:176)

TABLE 5 (continued)

No significant difference between admission rates of native and foreign-born whites. First admissions to all mental hospitals in New York State, 1944. (36:293)

Rates: Native white of native parentage 5.8, native white of foreign or mixed parentage 7.4, foreign-born white 13.5.—State and private hospitals, Chicago, 1922–34. (10a:115)

* Arizona, Colorado, Iowa, Maine, Massachusetts, Nebraska, New Hampshire, New York, Rhode Island, South Dakota, Virginia.

† Crude or unspecified type of rates (per 100,000 population).

TABLE 6. MENTAL DISORDERS AMONG NEGROES

ALL MENTAL DISORDERS

Rates: * Negro males 168.1, females 134.2, total 150.6; white males 82.0, females 65.4, total 73.7.—All institutions for mental disease in New York State, 1929–31. (44:229–31)

Military rejection rates highest for Negroes. Boston, Mass., 1941–42. Data based on 60,000 selectees. Percentages and rejection rates given for five major causes for rejection. (28:613–18)

With exception of mental deficiency and epilepsy Negro rates are lower than white rates. U.S. Army, 1917–19 (69,000 cases). (2:385)

Rates per 10,000 population: Negro males 12.5, females 9.3; white males 16.0, females 7.4.—First admissions to Arkansas State Hospital from Jefferson County, 1930–48. (1:188)

Rates: * Negro males 272.8, females 193.2, total 229.6; white males 115.4, females 105.3, total 110.3.—All hospitals for mental disease in New York State, 1939–41. (40:458)

Disproportionately high number of Negro admissions compared to Jewish, Catholic, and total white admissions. Based on 19,000 admissions to Bellevue Hospital, New York City, no date. (65:365)

ALL PSYCHOSES

Negro military rejection rate equal to rate for Irish, below rate for Italians, Jews, Old American, and higher than Chinese and Portuguese. Boston, Mass., 1941–42. Data based on 60,000 selectees. (28:614–18)

Negro rates lower than for white non-Jews and Jews. Based on a psychiatric survey in Baltimore, Eastern Health District, 1933–39. (61:32)

Rates (1933): Negro males 376.0, females 137.9; white males 172.3, females 138.9. *Rates (1933–36):* Negro males 250.7, females 143.6; white

males 161.2, females 116.2. *Prevalence rate* (1933): Negro males 827.3, females 390.7; white males 874.4, females 875.7.—Based on a psychiatric survey and on first admissions from Baltimore, Eastern Health District. (7:1394)

Negroes native to New York State had much lower rates than Negroes born elsewhere in the U.S. First admissions to all institutions for mental disease in New York State, 1929–31. (42:113)

Rates: Negro males 50.6, females 51.2; white males 49.5, females 42.1.—Georgia State Hospital, 1923–32. (23:204)

Incidence among Negroes almost twice that of whites. First admissions to Delaware State Hospital, 1950. (29:213)

Incidence among Negroes higher than among whites. First admissions to Georgia State Sanatorium, 1909–14. (21:698–702)

SCHIZOPHRENIA

Rates: * Negro males 46.9, females 42.1, total 44.4; white males 21.2, females 17.2, total 19.2.—All mental institutions in New York State, 1929–31. (44:229–31)

Rates per 1,000 population: Negroes .28, whites .27.—First admissions from Baltimore, Eastern Health District, 1933–39. (34:111)

Rates: * Negroes 26.3, whites 16.2.—Cincinnati General Hospital, 1936–37. (64:174)

Rates: Negro males 88.3, females 79.4, total 83.8; white males 40.3, females 37.6, total 39.0.—All hospitals for mental disease in New York State, 1939–41. (40:474)

Lower incidence among Negroes than among whites. First admissions to Delaware State Hospital, 1950. (29:213)

Most prevalent psychoses among Negroes. Based on admissions to the Government Hospital for the Insane, Washington, D.C., 1909–14. (49:322, 336)

Rates: * Negroes 12.5, whites 15.0—hospitals for mental disease in U.S.A., 1922. Negroes 48.6, whites 16.9—New York civil state hospitals, 1924. Negroes 57.1, white 15.6—Illinois state hospitals, 1924. (51:610–11)

Rates: Negro males 6.1, females 14.5; white males 5.6, females 9.1.—Georgia State Hospital, 1923–32. (23:204)

MANIC DEPRESSIVE

Rates: * Negro males 13.0, females 21.5, total 17.4; white males 7.9, females 12.0, total 10.0.—All mental institutions in New York State, 1929–31. (44:229–31)

Rates per 1,000 population: Negroes .13, whites .11.—First admissions from Baltimore, Eastern Health District, 1933–39. (34:111)

Rates: * Negroes 8.7, whites 4.7.—Cincinnati General Hospital, 1936–37. (64:174)

TABLE 6 (continued)

Approximately equal incidence among Negroes and whites. Negro female incidence three times as great as that of males. First admissions (1,700 cases) to St. Elizabeth's Hospital, New York City, 1908-29. (35:815)

Rates: Negro males 8.8, females 20.8, total 15.3; white males 6.5, females 11.7, total 9.1.—New York civil state hospitals, 1918-22. (52:662)

Rates: Negro males 11.6, females 13.3; white males 10.5, females 13.6.—Georgia state hospitals, 1923-32. (23:204)

Lower incidence among Negroes than among whites. First admissions to Delaware State Hospital, 1950. (29:213)

Lower incidence among Negroes than among whites. Based on admissions to the Government Hospital for the Insane, Washington, D.C., 1909-14. (49:322, 336)

Rates: Negroes 3.2, whites 7.7.—State and private hospitals, Chicago, 1922-34. (10a:74)

ALCOHOLIC PSYCHOSES

Rates: * Negro males 22.5, females 8.1, total 15.1; white males 7.3, females 1.3, total 4.3.—All mental institutions in New York State, 1929-31. (44:229-31)

Rates per 1,000 population: Negroes .19, whites .07.—First admissions from Baltimore, Eastern Health District, 1933-39. (34:111)

Rates: * Negroes 56.1, whites 21.3.—Cincinnati General Hospital, 1936-37. (64:174)

Rates: Negro males 67.2, females 16.9, total 41.6; white males 20.6, females 4.1, total 12.1.—All hospitals for mental disease in New York State, 1939-41. (40:474)

Negro incidence twice that of whites. First admissions to all state and licensed hospitals for mental disease in New York State, 1943-44. (36:292, 295)

Incidence among Negroes much higher than among whites. First admissions to Delaware State Hospital, 1950. (29:213)

Rates: Negroes 17.7, whites 10.0.—State and private hospitals, Chicago, 1922-34. (10a:115)

GENERAL PARESIS

Rates: * Negro males 36.9, females 13.9, total 25.0; white males 11.1, females 2.8, total 7.0.—All mental institutions in New York State, 1929-31. (44:229-31)

Rates: Negro males 77.4, females 22.7, total 49.6; white males 11.9, females 3.5, total 7.6.—All hospitals for mental disease in New York State, 1939-41. (40:474)

Rates: Negro males 9.0, females 3.1; white males 3.6, females 0.6.—Georgia State Hospital, 1923-32. (23:204)

Incidence among Negroes much higher than among whites. First admissions to Delaware State Hospital, 1950. (29:213)

Incidence among Negroes seven times as high as among whites: First admissions to all state and licensed hospitals for mental disease in New York state, 1944-45. (37:228)

Rates: Negroes 30.1, whites 11.9.—State and private hospitals, Chicago, 1922-34. (10a:129)

PSYCHONEUROSES

Rates: * Negro males—, females 0.5, total 0.3; white males 1.1, females 1.7, total 1.4.—All mental institutions in New York State, 1929-31. (44:229-31)

Military rejection rate highest for Negroes, followed by Chinese and Jews. Boston, Mass., 1941-42. Percentage rejection rates based on 60,000 selectees. (28:616)

Military rejection rates: Negroes 37, whites 39.3, per 1,000 men examined.—U.S. local draft boards and induction stations, 1942-43. (54:1086)

Incidence lower among Negroes than among whites: Data based on samples from U.S. Navy hospitals, during W. War II, no date. (26:133-34)

Rates: Negro males 3.4, females 8.1, total 5.8; white males 4.6, females 11.6, total 8.2.—Based on a psychiatric survey in Baltimore, Eastern Health District, 1936. (34:117)

Rates: Negroes 3.8, whites 5.2.—Cincinnati General Hospital, 1936-37. (64:174)

Rates: Negroes 87.6, whites 42.9.—State and private hospitals, Chicago, 1922-34. (10a:137)

SENILE PSYCHOSES

Rates: * Negro males 2.9, females 6.0, total 4.5; white males 5.7, females 7.9, total 6.8.—All mental institutions in New York State, 1929-31. (44:229-31)

Rates: Negro males 0.8, females 1.9; white males 1.8, females 2.2.—Georgia State Hospital, 1923-32. (23:204)

Lower incidence among Negroes than among whites. First admissions to Delaware State Hospital, 1950. (29:213)

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Rates: * Negro males 13.0, females 12.8, total 12.9; white males 11.6, females 8.8, total 10.2.—All mental institutions in New York State, 1929-31. (44:229-31)

Rates: Negro males 296.8, females 24.5, total 284.4; white males 99.2,

TABLE 6 (continued)

females 75.2, total 91.0.—All hospitals for mental disease in New York State, 1939-41. (40:474)

Rates: Negro males 6.2, females 3.2; white males 6.4, females 2.0.—Georgia State Hospital, 1923-32. (23:204)

Incidence among Negroes lower than among whites.—First admissions to Delaware State Hospital, 1950. (29:213)

INVOLUTIONAL PSYCHOSES

Rates: * Negro males 0.2, females 0.6, total 0.4; white males 1.5, females 2.9, total 2.2.—All mental institutions in New York State, 1929-31. (44:229-31)

Rates: Negroes 5.2, whites 6.4.—Cincinnati General Hospital, 1936-37. (64:174)

Rates: Negro males 0.8, females 3.5, total 2.2; white males 1.8, females 4.1, total 2.9.—Ohio state mental hospitals, 1951-52. (13a:243)

PARANOIA AND PARANOIC CONDITIONS

Rates: * Negro males 0.2, females 0.5, total 0.3, white males 0.7, females 0.8, total 0.8.—All mental institutions in New York State, 1929-31. (44:229-31)

* Crude rates (per 100,000 population).

TABLE 7. MENTAL DISORDERS AMONG JEWS

ALL MENTAL DISORDERS

Rates: * Jews 44.7, non-Jews 69.2 (1920). Jews 42.3, non-Jews 75.1 (1927).—New York civil state hospitals, 1920 and 1927. (43:283-84)

Rates: * Jews 42.7, non-Jews 81.1.—Admissions from New York City to public and private mental hospitals, 1925. (43:283-84)

Rates: * Jews 31.2, non-Jews 73.6.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 29.6, non-Jews 64.2.—Illinois state mental hospitals, 1926-28. (39:769)

Incidence for Jews proportionately lower than for non-Jews. Based on total admissions to psychiatric wards of Bellevue and Kings County hospitals, New York City, 1917-19. (20:602)

Rates per 10,000 population: Jews 9, non-Jews 13.—Based on admissions to Bellevue Hospital, New York City, 1909-1912. (3:514)

Disproportionately low number of Jews admitted to Bellevue Hospital, New York City. Data based on 19,000 admissions. (65:365)

SCHIZOPHRENIA

Rates: * Jews 16.0, non-Jews 23.5.—Admissions from New York City to public and private mental institutions, 1925. (43:283)

Rates: * Jews 11.4, non-Jews 16.2.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 13.7, non-Jews 16.0.—Illinois state mental hospitals, 1926-28. (39:769)

MANIC DEPRESSIVE

Rates: * Jews 10.0, non-Jews 11.3.—Admissions from New York City to public and private mental institutions, 1925. (43:283)

Rates: * Jews 7.0, non-Jews 8.4.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 1.8, non-Jews 3.1.—Illinois state mental hospitals, 1926-28. (39:769)

INVOLUTIONAL PSYCHOSES

Rates: * Jews 0.5, non-Jews 2.0.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 0.8, non-Jews 0.6.—Illinois state mental hospitals, 1926-28. (39:769)

GENERAL PARESIS

Rates: * Jews 4.2, non-Jews 10.3.—Admissions from New York City to public and private mental institutions, 1925. (43:283)

Rates: * Jews 2.2, non-Jews 5.2.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 3.2, non-Jews 7.9.—Illinois state mental hospitals, 1926-28. (39:769)

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Rates: * Jews 1.2, non-Jews 10.2.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 2.9, non-Jews 7.9.—Illinois state mental hospitals, 1926-28. (39:769)

ALCOHOLIC PSYCHOSES

Rates: * Jews 0.1, non-Jews 5.9.—Admissions from New York City to public and private mental institutions, 1925. (43:283)

Lowest incidence among ethnic groups examined. Boston, 60,000 military selectees, 1941-42. (28:614)

Rates: * Jews 0.1, non-Jews 5.2.—Massachusetts state mental hospitals, 1926-28. (39:768)

TABLE 7 (continued)

Rates: * Jews 0.3, non-Jews 4.9.—Illinois state mental hospitals, 1926-28. (39:769)

PSYCHONEUROSES

Higher incidence than non-Jews. Based on admissions (25,909) to Bellevue Hospital, New York City, 1938. (55:11)

Highest incidence among ethnic groups examined. Boston, 60,000 military selectees, 1941-42. (28:614)

Rates: * Jews 0.3, non-Jews 1.0.—Illinois state mental hospitals, 1926-28. (39:769)

PARANOIA

Rates: * Jews 0.1, non-Jews 1.9.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 0.1, non-Jews 0.4.—Illinois state mental hospitals, 1926-28. (39:769)

SENILE PSYCHOSES

Rates: * Jews 1.0, non-Jews 7.3.—Massachusetts state mental hospitals, 1926-28. (39:768)

Rates: * Jews 1.1, non-Jews 4.7.—Illinois state mental hospitals, 1926-28. (39:769)

* Crude or unspecified type of rates (per 100,000 population).

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Trends in Mental Disorder*

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and Alexander Marshall)*

THE various social sciences, like all disciplines possessing an individual history and a corps of specially trained practitioners, ask their own questions, and answer them in their own way. It is not often that the questions they ask are the layman's questions, or the answers they give ones that would satisfy a layman. When they ask a question which has served for decades as one of the common counters in discussions of modern life, and at the same time answer it—that is news.

It is in just this sense that a slim volume recently published by the Free Press (*Psychosis and Civilization*, by Herbert Goldhamer and Alexander Marshall, 126 pp., \$4.00) is news. The question it asks is: is it true that the frequency of mental disorder—specifically, of psychoses—has increased over the past hundred years? We know that enormous changes have occurred in the way we live in these hundred years. Many more of us live in cities, the cities are larger and noisier, we travel greater distances to and from work, are subject in larger measure to the tyranny of the clock and the need to oblige a superior—and in view of all this, it would appear a truism to assert that man, subjected to an increasingly inhuman (or at any rate nonhuman) environment, increasingly breaks down under the strain. And indeed, all around us are huge installations which we know house many thousands of the mentally disordered, and the budgets of state governments groan under the pressure of maintaining them and building more. Surely all this, if not new, is far more characteristic of our present-day lives than of life a hundred years ago. But *are* we sure?

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This would seem to be a question on which we cannot achieve certainty. For it does not appear very likely that we could find statistics for the 1840's and 1850's which would enable us to answer such a question. Previous studies had, indeed, not gone back very far—hence it was no surprise to find that some of them had discovered no change in the frequency of mental disease. The one study that went furthest back (to 1881, in Massachusetts) did show a rather large increase.

Goldhamer and Marshall decided to go back even further, and in effect constructed their own statistics on the basis of data from the state of Massachusetts beginning with the year 1840. At that time, there were only three institutions in the state devoted specifically to the insane—a private hospital in Boston, established in 1818 (McLean), the Worcester Hospital, then only eight years old, and the South Boston Hospital, then only one year old. In addition, the insane were received in state and town almshouses and in the prisons.

In view of these limited facilities, could the data on the insane be very complete or reliable? Goldhamer and Marshall argue that they were, and very effectively. Quoting from the early reports of the asylums and their superintendents, they demonstrate, for example, that a very clear distinction was made between the psychotic (then called "lunatics") and the mentally defective (then called "idiots"). The latter were almost entirely excluded from the limited places available in the asylums. In the same way, those suffering from epilepsy without psychosis and alcoholism without psychosis were also clearly demarcated from the psychotic, and for the most part excluded. The detailed descriptions of the disorders from which the lunatics of the 1840's and 1850's suffered indicate clearly that we deal with the very same diseases—even though "mania," "melancholia," "dementia," and "monomania of suspicion" had to make do, in those days, to describe what we currently call "manic-depressive psychosis," "schizophrenia," and "paranoia." The authors carefully exclude the possibilities of error related to the readmission of patients (all of the figures quoted here refer to first admissions), or to the chance that the mentally ill of Massachusetts went out of the state for treatment (not likely, in view of the fact that Massachusetts then—as now—had facilities for the insane as good or better than any other state in the union), or to the fact that the hospitals of Massachusetts contained out-of-state

patients (they did, but the record-keeping was excellent, and these can be excluded).

In short, with a most exemplary and remarkable care and precision, the authors of this study establish rates for the frequency of admission for psychosis in Massachusetts for the years 1840 to 1885, rates that must be very close to the true ones and which in any case will not be easily improved upon.

The rates thus established rise from 41 per 100,000 for 1840-45 to 58 per 100,000 in 1880-84. (This rise is undoubtedly a product of the increase in facilities during the period.) These rates seem at first glance much lower than the rate of admissions in 1940: the 1940 admission rate, applied to a population with the age structure of that of the 1840's, would give a rate today of 85 per 100,000, and applied to the population of the 1880's, 91 per 100,000.

However, when one breaks down these over-all rates of admission to examine the rate for each age group, a remarkable and most meaningful difference in the pattern of admissions appears. The 1940 rate rises rapidly for the ages from ten to about thirty, then is about the same for those aged from thirty to fifty, then begins to rise rapidly again, to become very high for the old. In the 19th century, we find the same rise in the rate of admissions for the young, the same plateau between the ages of thirty and fifty, and then a drop in the rate of admissions past the age of fifty. *The differences between the 19th-century period and our own day are created entirely by the large number of admissions for psychoses of those older than fifty today. Up to the age of fifty, the rates a hundred years ago and today are roughly the same.* (As we shall see later, there is a technical reason having to do with change in admissions practices that accounts for the rise in the over-fifty group.)

It seems almost inconceivable that this should be the case. Even if there has been no real increase in the frequency of psychosis, one would expect a great increase in the number of hospitalized psychotics. For, comparing the situation today with that in even as late a year as 1885, we find that facilities are much more plentiful and easily available, that the popular attitude toward hospitalization for mental disease is much more favorable, that nonpsychotic disorders such as alcoholism, idiocy, and even psychoneuroses are increasingly dealt with in mental hospitals.

Yet, no matter what our bases of comparison, the frequency of psychosis in the middle of the 19th century is not less than it is today. The earliest rates on record for Massachusetts, for 1840-44, when, as we have indicated, there were few facilities and those only in existence a few years, exceed, for ages thirty to sixty, those for the state of Maine in 1940. And the admission rates for psychosis in Suffolk County—that is, Boston—were in 1875-79 higher than they were in New York City in 1929-31, for all ages up to fifty-five! Even as early as 1840-45, the Suffolk County rate was higher than the New York City rate for the age group forty to sixty. A comparison of the rates in 1885 and 1930 "reveals that the male 1885 rate for the . . . age group 20-40 slightly exceeds that of the contemporary period and that the 1885 female rates for ages 20-50 exceed the corresponding 1930 figures."

Nor do we deal with an exceptional situation when we deal with Massachusetts. The authors carefully consider any factor that might have tended to lead to a higher frequency of mental disease in Massachusetts in the period from 1840 to 1885. Thus, they examine the bearing of the proportion of foreign-born, which was low at the beginning of this period (5 per cent in 1840) but rose rapidly, with the Irish immigration, to become quite high by the end of the period (1860, 21 per cent; 1870, 24 per cent; 1880, 25 per cent). However, this proportion of foreign-born has since been fairly constant (it was also 25 per cent in 1930) and could therefore not have been the cause of a peculiarly high rate of psychosis in the middle of the 19th century.

Nor is it the fact that Massachusetts was, among all the states of the union, particularly prone to mental disorder in the middle of the 19th century. Wherever we can find figures, we will find about as much psychosis—that is to say, admissions to hospitals for psychosis—in the 19th century as in the 20th. Thus, Oneida County, in New York State, had easy access to a state hospital established in Utica in 1843. The rate of admissions from 1843 to 1865 for the age group from thirty to fifty is only slightly below the 1930 New York State rate (adjusted for the rural-urban proportion that prevailed in Oneida County during this period). Perhaps most remarkable of all is the case of Fayette County, Kentucky, which had access to the hospital in Lexington, and for which we have figures from as early as 1824. For the years 1824 to 1842 (at the earlier date, Kentucky was scarcely out of the frontier

stage), this county "had [a] higher total admission rate in the central age groups than . . . Kentucky . . . today."

Even before we begin to try to understand why there should have been as much psychosis in the middle years of the 19th century as there is today, we have to consider how it was physically possible for admissions for psychosis to the few institutions that existed in the 1840's to give a rate, even if only for certain age groups, equal to that of today.

There are a number of factors pointed to by Goldhamer and Marshall that are relevant. The first institutions opened specifically for the insane were established for those who created the worst problems for society—thus, the Worcester Hospital in Massachusetts was specifically limited to the "violent and furious." Those psychoses associated with senility, which are responsible for such a large proportion of the inmates of present-day mental hospitals, were in effect ruled out by this definition, and it was only much later that such persons were taken into hospitals. Idiots and those of subnormal intelligence were also ruled out. In effect, these hospitals were established for persons afflicted with manic-depressive psychosis, paranoia, and some of the forms of schizophrenia. These are diseases which characteristically strike young people and people in the middle years of life. It was such people who filled the new hospitals established in the 30's, 40's, and 50's of the 19th century. The psychoses of senility, which are responsible for the presence of most of the aged in our hospitals, and subnormal intelligence, which is responsible for a large proportion of the young, were both managed within the family. And since families were larger, and their living quarters also larger, there was no great tendency to hospitalize these unfortunates.

Consequently, Goldhamer and Marshall argue that even the great increase which has taken place in the last century in the proportions of old people hospitalized for psychosis is an increase only in hospitalization, not in actual frequency. Sufferers from the psychoses of senility, they argue, quoting contemporary records and the advice of leading doctors of the time, remained at home, and there was little pressure to get them into hospitals.

Similarly, the much smaller increase that has occurred in the numbers of young people (under twenty) hospitalized does not indicate a real increase of psychosis in this group, for a very large proportion of those in this age group today are hospitalized for

non-psychotic conditions.

In other words: even where we see an apparent increase over a hundred years ago in the numbers in our state hospitals today (that is, among those under twenty and over fifty), the increase can be explained by the expansion of facilities.

What are we to conclude from all this? The authors of this study are extremely cautious. All we can conclude, they say, is that there has been no great change in the conditions causing psychosis in this country in the past hundred years. Possibly if we could carry our study back another hundred years we would find a great change; possibly by 1840 those conditions of modern life that people believe lead to mental disorder had already been established. But it is not likely that any statistical studies can carry us back before 1840. It is also possible there has been a great increase in the frequency of neurosis; but this is a difficult matter to test statistically.

Another conclusion, they point out, is compatible with these results: that is, that in psychosis we deal with a condition which is independent of environmental circumstances, a condition dependent on heredity or physiological aberration, which, like some physical diseases, strikes a certain proportion of the population. The authors refer to a recent study of the frequency of psychosis on the Danish island of Bornholm, an island inhabited principally by farmers and fishermen. It turns out that the frequency of psychosis there is roughly what we find in New York State. Were it not for this finding, one might be tempted to suggest that the trauma of leaving one's home and emerging across the ocean had affected Americans in general so deeply that the same proportion of psychosis existed among frontiersmen as among city dwellers. However, the Bornholm study shows us that even where the population has deep roots, we find the same measure of mental disorder as in America.

We do not yet know enough to be able to do more than speculate as to the implications of these findings. We already know enough, however, to lay to rest one of the most popular clichés of our culture, one that we run into again and again in sociological, political, and religious writing, and which has often served as the basis for very lazy conclusions. We may hope that the Goldhamer and Marshall study will be only the first of a series analyzing the records of different countries, and different times.

SEVEN

Social Stratification and Psychiatric Disorders*

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THE research reported here grew out of the work of a number of men, who, during the last half century, have demonstrated that the social environment in which individuals live is connected in some way, as yet not fully explained, to the development of mental illness.¹ Medical men have approached this problem largely from the viewpoint of epidemiology.² Sociologists, on the other

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¹ For example, see, A. J. Rosanoff, *Report of a Survey of Mental Disorders in Nassau County, New York*, New York: National Committee for Mental Hygiene, 1916; Ludwig Stern, *Kulturkreis und Form der Geistigen Erkrankung* (Sammlung Zwanglosen Abhandlungen aus dem Gebiete der Nerven- und Geisteskrankheiten), X, No. 2, Halle a. S.: C. Marhold, 1913, pp. 1-62; J. F. Sutherland, "Geographical Distribution of Lunacy in Scotland," *British Association for Advancement of Science*, Glasgow, Sept. 1901; William A. White, "Geographical Distribution of Insanity in the United States," *Journal of Nervous and Mental Diseases*, XXX (1903), pp. 257-279.

² For example, see: Trygve Braatoy, "Is it Probable that the Sociological Situation is a Factor in Schizophrenia?" *Psychiatria et Neurologica*, XII (1937), pp. 109-138; Donald L. Gerard and Joseph Siegel, "The Family Background of Schizophrenia," *The Psychiatric Quarterly*, 14 (January, 1950), pp. 47-73; Robert W. Hyde and Lowell V. Kingsley, "Studies in Medical Sociology, I: The Relation of Mental Disorders to the Community Socio-economic Level," *The New England Journal of Medicine*, 231, No. 16 (October 19, 1944), pp. 543-548; Robert W. Hyde and Lowell V. Kingsley, "Studies in Medical Sociology, II: The Relation of Mental Disorders to Population Density," *The New England Journal of Medicine*, 231, No. 17 (October 26,

hand, have analyzed the question in terms of ecology,³ and of social disorganization.⁴ Neither psychiatrists nor sociologists have carried on extensive research into the specific question we are concerned with, namely, interrelations between the class structure and the development of mental illness. However, a few sociologists and psychiatrists have written speculative and research papers in this area.⁵

1944), pp. 571-577; Robert M. Hyde and Roderick M. Chisholm, "Studies in Medical Sociology, III: The Relation of Mental Disorders to Race and Nationality," *The New England Journal of Medicine*, 231, No. 18 (November 2, 1944), pp. 612-618; William Malamud and Irene Malamud, "A Socio-Psychiatric Investigation of Schizophrenia Occurring in the Armed Forces," *Psychosomatic Medicine*, 5 (October, 1943), pp. 364-375; B. Malzberg, *Social and Biological Aspects of Mental Disease*, Utica, N. Y.: State Hospital Press, 1940; William F. Roth and Frank H. Luton, "The Mental Health Program in Tennessee: Statistical Report of a Psychiatric Survey in a Rural County," *American Journal of Psychiatry*, 99 (March, 1943), pp. 662-675; J. Ruesch and others, *Chronic Disease and Psychological Invalidism*, New York: American Society for Research in Psychosomatic Problems, 1946; J. Ruesch and others, *Duodenal Ulcer: A Socio-psychological Study of Naval Enlisted Personnel and Civilians*, Berkeley and Los Angeles: University of California Press, 1948; Jurgen Ruesch, Annemarie Jacobson, and Martin B. Loeb, "Acculturation and Illness," *Psychological Monographs: General and Applied*, Vol. 62, No. 5, Whole No. 292, 1948 (American Psychological Association, 1515 Massachusetts Ave., N.W., Washington 5, D. C.); C. Tietze, Paul Lemkau and M. Cooper, "A Survey of Statistical Studies on the Prevalence and Incidence of Mental Disorders in Sample Populations," *Public Health Reports*, 1909-27, 58 (December 31, 1943); C. Tietze, P. Lemkau and Marcia Cooper, "Schizophrenia, Manic Depressive Psychosis and Social-Economic Status," *American Journal of Sociology*, XLVII (September, 1941), pp. 167-175.

³ Robert E. L. Faris, and H. Warren Dunham, *Mental Disorders in Urban Areas*, Chicago: University of Chicago Press, 1939; H. Warren Dunham, "Current Status of Ecological Research in Mental Disorder," *Social Forces*, 25 (March, 1947), pp. 321-326 (No. 10 in this volume); R. H. Felix and R. V. Bowers, "Mental Hygiene and Socio-Environmental Factors," *The Milbank Memorial Fund Quarterly*, XXVI (April, 1948), pp. 125-147; H. W. Green, *Persons Admitted to the Cleveland State Hospital, 1928-1937*, Cleveland Health Council, 1939.

⁴ R. E. L. Faris, "Cultural Isolation and the Schizophrenic Personality," *American Journal of Sociology*, XXXIX (September, 1934), pp. 155-169; R. E. L. Faris, "Reflections of Social Disorganization in the Behavior of a Schizophrenic Patient," *American Journal of Sociology*, L (September, 1944), pp. 134-141 (No. 17 in this volume).

⁵ For example, see: Robert E. Clark, "Psychoses, Income, and Occupational Prestige," *American Journal of Sociology*, 44 (March, 1940), pp. 433-440; Robert E. Clark, "The Relationship of Schizophrenia to Occupational Income and Occupational Prestige," *American Sociological Review*, 13 (June, 1948), pp. 325-330; Kingsley Davis, "Mental Hygiene and the Class Structure,"

The present research, therefore, was designed to discover whether a relationship does or does not exist between the class system of our society and mental illnesses. Five general hypotheses were formulated in our research plan to test some dimension of an assumed relationship between the two. These hypotheses were stated positively; they could just as easily have been expressed either negatively or conditionally. They were phrased as follows:

I. The *expectancy* of a psychiatric disorder is related significantly to an individual's position in the class structure of his society.

II. The *types* of psychiatric disorders are connected significantly to the class structure.

III. The type of *psychiatric treatment* administered is associated with patient's position in the class structure.

IV. The *psycho-dynamics* of psychiatric disorders are correlative to an individual's position in the class structure.

V. *Mobility* in the class structure is neurotogenic.

Each hypothesis is linked to the others, and all are subsumed under the theoretical assumption of a functional relationship between stratification in society and the prevalence of particular types of mental disorders among given social classes or strata in a specified population. Although our research was planned around these hypotheses, we have been forced by the nature of the problem of mental illness to study *diagnosed* prevalence of psychiatric disorders, rather than *true* or *total* prevalence.

METHODOLOGICAL PROCEDURE

The research is being done by a team of four psychiatrists,⁶ two sociologists,⁷ and a clinical psychologist.⁸ The data are being as-
Psychiatry, I (February, 1938), pp. 55-56 (No. 37 in this volume); Talcott Parsons, "Psychoanalysis and the Social Structure," *The Psychoanalytical Quarterly*, XIX, No. 3 (1950), pp. 371-384; John Dollard and Neal Miller, *Personality and Psychotherapy*, New York: McGraw-Hill, 1950; Jurgen Ruesch, "Social Technique, Social Status, and Social Change in Illness," Clyde Kluckhohn and Henry A. Murray (editors), in *Personality in Nature, Society, and Culture*, New York: Alfred A. Knopf, 1949, pp. 117-130; W. L. Warner, "The Society, the Individual and His Mental Disorders," *American Journal of Psychiatry*, 94, No. 2 (September, 1937), pp. 275-284.

⁶ F. C. Redlich, B. H. Roberts, L. Z. Freedman, and Leslie Schaffer.

⁷ August B. Hollingshead and J. K. Myers.

⁸ Harvey A. Robinson.

sembled in the New Haven urban community, which consists of the city of New Haven and surrounding towns of East Haven, North Haven, West Haven, and Hamden. This community had a population of some 250,000 persons in 1950.⁹ The New Haven community was selected because the community's structure has been studied intensively by sociologists over a long period. In addition, it is served by a private psychiatric hospital, three psychiatric clinics, and 27 practicing psychiatrists, as well as the state and Veterans Administration facilities.

Four basic technical operations had to be completed before the hypotheses could be tested. These were: the delineation of the class structure of the community, selection of a cross-sectional control of the community's population, the determination of who was receiving psychiatric care, and the stratification of both the control sample and the psychiatric patients.

August B. Hollingshead and Jerome K. Myers took over the task of delineating the class system. Fortunately, Maurice R. Davie and his students had studied the social structure of the New Haven community in great detail over a long time span.¹⁰ Thus, we had a large body of data we could draw upon to aid us in blocking out the community's social structure.

The community's social structure is differentiated *vertically* along racial, ethnic, and religious lines; each of these vertical cleavages, in turn, is differentiated *horizontally* by a series of strata or classes. Around the socio-biological axis of race two social worlds have evolved: A Negro world and a white world. The white world is divided by ethnic origin and religion into Catholic, Protestant, and Jewish contingents. Within these divisions there are numerous ethnic groups. The Irish hold aloof from the Italians, and the Italians move in different circles from the Poles. The Jews

⁹ The population of each component was as follows: New Haven, 164,443; East Haven, 12,212; North Haven, 9,444; West Haven, 32,010; Hamden, 29,715; and Woodbridge, 2,822.

¹⁰ Maurice R. Davie, "The Pattern of Urban Growth," G. P. Murdock (editor), in *Studies in the Science of Society*, New Haven: 1937, pp. 133-162; Ruby J. R. Kennedy, "Single or Triple Melting-Pot: Intermarriage Trends in New Haven, 1870-1940," *American Journal of Sociology*, 39 (January, 1944), pp. 331-339; John W. McConnell, *The Influence of Occupation Upon Social Stratification*, Unpublished Ph.D. thesis, Sterling Memorial Library, Yale University, 1937; Jerome K. Myers, "Assimilation to the Ecological and Social Systems of a Community," *American Sociological Review*, 15 (June, 1950), pp. 367-372; Mhyra Minnis, "The Relationship of Women's Organizations to the Social Structure of a City," Unpublished Ph.D. thesis, Sterling Memorial Library, Yale University, 1951.

maintain a religious and social life separate from the gentiles. The *horizontal* strata that transect each of these vertical divisions are based upon the social values that are attached to occupation, education, place of residence in the community, and associations.

The vertically differentiating factors of race, religion and ethnic origin, when combined with the horizontally differentiating ones of occupation, education, place of residence and so on, produce a social structure that is highly compartmentalized. The integrating factors in this complex are twofold. First, each stratum of each vertical division is similar in its cultural characteristics to the corresponding stratum in the other divisions. Second, the cultural pattern for each stratum or class was set by the "Old Yankee" core group. This core group provided the master cultural mold that has shaped the status system of each sub-group in the community. In short, the social structure of the New Haven community is a parallel class structure within the limits of race, ethnic origin, and religion.

This fact enabled us to stratify the community, for our purposes, with an *Index of Social Position*.¹¹ This *Index* utilizes three scaled factors to determine an individual's class position within the community's stratificational system: ecological area of residence, occupation, and education. Ecological area of residence is measured by a six point scale; occupation and education are each measured by a seven point scale. To obtain a social class score on an individual we must therefore know his address, his occupation, and the number of years of school he has completed. Each of these factors is given a scale score, and the scale score is multiplied by a factor weight determined by a standard regression equation. The factor weights are as follows: Ecological area of residence, 5; occupation, 8; and education, 6. The three factor scores are summed, and the resultant score is taken as an index of this individual's position in the community's social class system.

This *Index* enabled us to delineate five main social class strata within the horizontal dimension of the social structure. These principal strata or classes may be characterized as follows:

Class 1. This stratum is composed of wealthy families whose wealth is often inherited and whose heads are leaders in the community's business and professional pursuits. Its members live in

¹¹ A detailed statement of the procedures used to develop and validate this *Index* will be described in a forthcoming monograph on this research tentatively titled *Psychiatry and Social Class* by August B. Hollingshead and Frederick C. Redlich.

those areas of the community generally regarded as "the best;" the adults are college graduates, usually from famous private institutions, and almost all gentile families are listed in the *New Haven Social Directory*, but few Jewish families are listed. In brief, these people occupy positions of high social prestige.

Class II. Adults in this stratum are almost all college graduates; the males occupy high managerial positions, many are engaged in the lesser ranking professions. These families are well-to-do, but there is no substantial inherited or acquired wealth. Its members live in the "better" residential areas; about one-half of these families belong to lesser ranking private clubs, but only 5 per cent of Class II families are listed in the *New Haven Social Directory*.

Class III. This stratum includes the vast majority of small proprietors, white-collar office and sales workers, and a considerable number of skilled manual workers. Adults are predominately high school graduates, but a considerable percentage have attended business schools and small colleges for a year or two. They live in "good" residential areas; less than 5 per cent belong to private clubs, but they are not included in the *Social Directory*. Their social life tends to be concentrated in the family, the church, and the lodge.

Class IV. This stratum consists predominately of semi-skilled factory workers. Its adult members have finished the elementary grades, but the older people have not completed high school. However, adults under thirty-five have generally graduated from high school. Its members comprise almost one-half of the community; and their residences are scattered over wide areas. Social life is centered in the family, the neighborhood, the labor union, and public places.

Class V. Occupationally, class V adults are overwhelmingly semi-skilled factory hands and unskilled laborers. Educationally most adults have not completed the elementary grades. The families are concentrated in the "tenement" and "cold-water flat" areas of New Haven. Only a small minority belong to organized community institutions. Their social life takes place in the family flat, on the street, or in neighborhood social agencies.

The second major technical operation in this research was the enumeration of psychiatric patients. A Psychiatric Census was taken to discover the number and kinds of psychiatric patients in the community. Enumeration was limited to residents of the com-

munity who were patients of a psychiatrist or a psychiatric clinic, or were in a psychiatric institution on December 1, 1950. To make reasonably certain that all patients were included in the enumeration, the research team gathered data from all public and private psychiatric institutions and clinics in Connecticut and nearby states, and all private practitioners in Connecticut and the metropolitan New York area. It received the cooperation of all clinics and institutions, and of all practitioners except a small number in New York City. It can be reasonably assumed that we have data comprising at least 98 per cent of all individuals who were receiving psychiatric care on December 1, 1950.

Forty-four pertinent items of information were gathered on each patient and placed on a schedule. The psychiatrists gathered material regarding symptomatology and diagnosis, onset of illness and duration, referral to the practitioner and the institution, and the nature and intensity of treatment. The sociologists obtained information on age, sex, occupation, education, religion, race and ethnicity, family history, marital experiences, and so on.

The third technical research operation was the selection of a control sample from the normal population of the community. The sociologists drew a 5 per cent random sample of households in the community from the 1951, *New Haven City Directory*. This directory covers the entire communal area. The names and addresses in it were compiled in October and November, 1950—a period very close to the date of the Psychiatric Census. Therefore there was comparability of residence and date of registry between the two population groups. Each household drawn in the sample was interviewed, and data on the age, sex, occupation, education, religion, and income of family members, as well as other items necessary for our purposes were placed on a schedule. This sample is our Control Population.

Our fourth basic operation was the stratification of the psychiatric patients and of the control population with the *Index of Social Position*. As soon as these tasks were completed, the schedules from the Psychiatric Census and the 5 per cent Control Sample were edited and coded, and their data were placed on Hollerith cards. The analysis of these data is in process.

SELECTED FINDINGS

Before we discuss our findings relative to Hypothesis I, we want to re-emphasize that our study is concerned with *diagnosed* or *treated* prevalence rather than *true* or *total* prevalence. Our Psychiatric Census included only psychiatric cases under treatment, diagnostic study, or care. It did not include individuals with psychiatric disorders who were not being treated on December 1, 1950, by a psychiatrist. There are undoubtedly many individuals in the community with psychiatric problems who escaped our net. If we had *true* prevalence figures, many findings from our present study would be more meaningful, perhaps some of our interpretations would be changed, but at present we must limit ourselves to the data we have.

Hypothesis I, as revised by the nature of the problem, stated: *The diagnosed prevalence of psychiatric disorders is related significantly to an individual's position in the class structure.* A test of this hypothesis involves a comparison of the normal population with the psychiatric population. If no significant difference between the distribution of the normal population and the psychiatric patient population by social class is found, Hypothesis I may be abandoned as unproved. However, if a significant difference is found between the two populations by class, Hypothesis I should be entertained until more conclusive data are assembled. Pertinent data for a limited test of Hypothesis I are presented in Table 1.

TABLE 1. DISTRIBUTION OF NORMAL AND PSYCHIATRIC POPULATION BY SOCIAL CLASS

Social Class	Normal Population *		Psychiatric Population	
	Number	Per cent	Number	Per cent
I	358	3.1	19	1.0
II	926	8.1	131	6.7
III	2,500	22.0	260	13.2
IV	5,256	46.0	758	38.6
V	2,037	17.8	723	36.8
Unknown †	345	3.0	72	3.7
Total	11,422	100.0	1,963	100.0

Chi square = 408.16, P less than .001.

* These figures are preliminary. They do not include Yale students, transients, institutionalized persons, and refusals.

† The unknown cases were not used in the calculation of chi square. They are individuals drawn in the sample, and psychiatric cases whose class level could not be determined because of paucity of data.

The data included show the number of individuals in the normal population and the psychiatric population, by class level. What we are concerned with in this test is how these two populations are distributed by class.

When we tested the reliability of these population distributions by the use of the chi square method, we found a *very significant* relation between social class and treated prevalence of psychiatric disorders in the New Haven community. A comparison of the percentage distribution of each population by class readily indicates the direction of the class concentration of psychiatric cases. For example, Class I contains 3.1 per cent of the community's population but only 1.0 per cent of the psychiatric cases. Class V, on the other hand, includes 17.8 per cent of the community's population, but contributed 36.8 per cent of the psychiatric patients. On the basis of our data Hypothesis I clearly should be accepted as tenable.

Hypothesis II postulated a significant connection between the *type* of psychiatric disorder and social class. This hypothesis involves a test of the idea that there may be a functional relationship between an individual's position in the class system and the type of psychiatric disorder that he may present. This hypothesis depends, in part, on the question of diagnosis. Our psychiatrists based their diagnoses on the classificatory system developed by the Veterans Administration.¹² For the purposes of this paper, all cases are grouped into two categories: the neuroses and the psychoses. The results of this grouping by social class are given in Table 2.

A study of Table 2 will show that the neuroses are concentrated at the higher levels and the psychoses at the lower end of the class

TABLE 2. DISTRIBUTION OF NEUROSES AND PSYCHOSES BY SOCIAL CLASS

Social Class	Neuroses		Psychoses	
	Number	Per cent	Number	Per cent
I	10	52.6	9	47.4
II	88	67.2	43	32.8
III	115	44.2	145	55.8
IV	175	23.1	583	76.9
V	61	8.4	662	91.6
Total	449		1,442	

Chi square = 196.45, P less than .001.

¹² *Psychiatric Disorders and Reaction*. Washington: Veterans Administration, Technical Bulletin 10A-78, October, 1947.

structure. Our team advanced a number of theories to explain the sharp differences between the neuroses and psychoses by social class. One suggestion was that the low percentage of neurotics in the lower classes was a direct reaction to the cost of psychiatric treatment. But as we accumulated a series of case studies, for tests of Hypotheses IV and V, we became skeptical of this simple interpretation. Our detailed case records indicate that the social distance between psychiatrist and patient may be more potent than economic considerations in determining the character of psychiatric intervention. This question therefore requires further research.

The high concentration of psychotics in the lower strata is probably the product of a very unequal distribution of psychotics in the total population. To test this idea, Hollingshead selected schizophrenics for special study. Because of the severity of this disease it is probable that very few schizophrenics fail to receive some kind of psychiatric care. This diagnostic group comprises 44.2 per cent of all patients, and 58.7 per cent of the psychotics, in our study. Ninety-seven and six-tenths per cent of these schizophrenic patients had been hospitalized at one time or another, and 94 per cent were hospitalized at the time of our census. When we classify these patients by social class we find that there is a very significant inverse relationship between social class and schizophrenia.

Hollingshead decided to determine, on the basis of these data, what the probability of the prevalence of schizophrenia by social class might be in the general population. To do this he used a proportional index to learn whether or not there were differentials in the distribution of the general population, as represented in our control sample, and the distribution of schizophrenics by social class. If a social class exhibits the same proportion of schizophrenia as it comprises of the general population, the index for that class is 100. If schizophrenia is disproportionately prevalent in a social class the index is above 100; if schizophrenia is disproportionately low in a social class the index is below 100. The index for each social class appears in the last column of Table 3.

The fact that the Index of Prevalence in class I is only one-fifth as great as it would be if schizophrenia were proportionately distributed in this class, and that it is two and one-half times as high in class V as we might expect on the basis of proportional distribution, gives further support to Hypothesis II. The fact that the

Index of Prevalence is 11.2 times as great in class V as in class I is particularly impressive.

Hypothesis III stipulated that the type of psychiatric treatment a patient receives is associated with his position in the class

TABLE 3. COMPARISON OF THE DISTRIBUTION OF THE NORMAL POPULATION WITH SCHIZOPHRENICS BY CLASS, WITH INDEX OF PROBABLE PREVALENCE

Social Class	Normal Population		Schizophrenics		Index of Prevalence
	No.	Per cent	No.	Per cent	
I	358	3.2	6	.7	22
II	926	8.4	23	2.7	33
III	2,500	22.6	83	9.8	43
IV	5,256	47.4	352	41.6	88
V	2,037	18.4	383	45.2	246
Total	11,077	100.0	847	100.0	

structure. A test of this hypothesis involves a comparison of the different types of therapy being used by psychiatrists on patients in the different social classes. We encountered many forms of therapy but they may be grouped under three main types; psychotherapy, organic therapy, and custodial care. The patient population, from the viewpoint of the principal type of therapy received, was divided roughly into three categories: 32.0 per cent received some type of psychotherapy; 31.7 per cent received organic treatments of one kind or another; and 36.3 per cent received custodial care without treatment. The percentage of persons who received no treatment care was greatest in the lower classes. The same finding applies to organic treatment. Psychotherapy, on the other hand, was concentrated in the higher classes. Within the psychotherapy category there were sharp differences between the types of psychotherapy administered to the several classes. For example, psychoanalysis was limited to classes I and II. Patients in class V who received any psychotherapy were treated by group methods in the state hospitals. The number and percentage of patients who received each type of therapy is given in Table 4. The data clearly support Hypothesis III.

At the moment we do not have data available for a test of Hypotheses IV and V. These will be put to a test as soon as we complete work on a series of cases now under close study. Preliminary materials give us the impression that they too will be confirmed.

TABLE 4. DISTRIBUTION OF THE PRINCIPAL TYPES OF THERAPY BY SOCIAL CLASS

Social Class	<i>Psychotherapy</i>		<i>Organic Therapy</i>		<i>No Treatment</i>	
	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>
I	14	73.7	2	10.5	3	15.8
II	107	81.7	15	11.4	9	6.9
III	136	52.7	74	28.7	48	18.6
IV	237	31.1	288	37.1	242	31.8
V	115	16.1	234	32.7	367	51.2

Chi square = 336.58, P less than .001.

CONCLUSIONS AND INTERPRETATIONS

This study was designed to throw new light upon the question of how mental illness is related to social environment. It approached this problem from the perspective of social class to determine if an individual's position in the social system was associated significantly with the development of psychiatric disorders. It proceeded on the theoretical assumption that if mental illnesses were distributed randomly in the population, the hypotheses designed to test the idea that psychiatric disorders are connected in some functional way to the class system would not be found to be statistically significant.

The data we have assembled demonstrate conclusively that mental illness, as measured by diagnosed prevalence, is not distributed randomly in the population of the New Haven community. On the contrary, psychiatric difficulties of so serious a nature that they reach the attention of a psychiatrist are unequally distributed among the five social classes. In addition, types of psychiatric disorders, and the ways patients are treated, are strongly associated with social class position.

The statistical tests of our hypotheses indicate that there are definite connections between particular types of social environments in which people live, as measured by the social class concept, and the emergence of particular kinds of psychiatric disorders, as measured by psychiatric diagnosis. They do not tell us what these connections are, nor how they are functionally related to a particular type of mental illness in a given individual. The next step, we believe, is to turn from the strictly statistical approach to an intensive study of the social environments as-

sociated with particular social classes, on the one hand, and of individuals in these environments who do or do not develop mental illnesses, on the other hand. Currently the research team is engaged in this next step but is not yet ready to make a formal report of its findings.

EIGHT

Occupation and Major Mental Disorders

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INTRODUCTION¹

ONE AREA of social psychiatry in which research is needed is that dealing with the etiology of mental illness.² It is the main purpose of this study to investigate an aspect of this field which, in the opinion of the writer, warrants further study,³ viz., the relation of occupation and major mental disorders.

Few studies have been done specifically on the subject of occupation and mental illness. However, the results of previous studies seem to indicate that there might exist some relationship between the *type* of mental illness an individual becomes affected with and his occupation. They also suggest that some relationship might exist between the *prevalence* of mental illness and one's occupation. Because income and prestige are closely related to one's socio-economic status, we might suggest that *occupation is an index of socio-economic status*. Therefore, what is true for a person of a given occupation might also be true for a person of a given socio-economic status. It thus follows that there exists, perhaps, some relationship between social class and mental illness, since socio-economic status is generally a determinant of social class.

This study has as its main objective the better understanding of

* Prepared especially for this volume.

¹ A major portion of the statistical data in this study was collected by the staff of the Bureau of Research and Statistics of the Ohio State Department of Public Welfare under the direction of Donald E. Smeltzer, Supervisor of Research and Statistics. The writer is especially indebted to Mr. Smeltzer for his co-operation in making these data available.

² R. A. Schermerhorn, "Needed Research in Social Psychiatry," *Social Problems*, 1 (June, 1953), 17-22.

³ R. M. Frumkin, "Occupation and Mental Illness," *Public Welfare Statistics*, 7 (September, 1952), 4-13.

the more important causal nexuses of occupation and major mental disorders in relation to the factors discussed above.

HISTORICAL BACKGROUND

About eighty years ago more than half the people who worked for a living were employed in agriculture. At that time the United States was mainly a farming country and much of its stability was based on the stability characteristic of the rural way of life. Since that time significant changes have occurred. There has been a rapid growth in industry, commerce, and other nonfarming employment. The severe drop in employment in nonfarm industries which marked the onset of the depression in 1929 and the depression decade that followed have had some long-term effects which should be noted in any consideration of the problem of occupation and mental illness. Some of the significant effects were these:

1. Young people and older people found it particularly difficult to obtain jobs.
2. Employers faced with the necessity of saving money raised their hiring standards. Only the best-trained or most-experienced workers got jobs. This hastened the long-term trend toward a preference for job applicants who had education.
3. People got jobs where they could. There was a great deal of occupational shifting down the scale of skills. The skills of many craftsmen and professional people grew rusty from disuse.
4. To preserve the employment security of their members and to prevent poorly trained people from entering their fields, some unions and professional societies took action to tighten up entrance requirements. This represented the continuation of the long-term trend toward raising the standards of education and training, especially in professional fields.⁴

One of the most provocative theses on occupation as it related to the American social structure was recently made by Drucker. He contends that "American society during the last fifty years has become an employee society; the employer has disappeared. It is a hierarchical system in which one is related to other people through his relationship to a strictly impersonal, objective, abstract

⁴ U. S. Department of Labor, *Occupational Outlook Handbook*. Bulletin No. 998 (Washington, D.C., 1951).

thing, the 'organization', a society based and ruled by status."⁵ Although Drucker's thesis points up the great significance of employeeship in relation to status, the writer cannot agree with the implication that employeeship per se is the *only* dimension of status. Are there not other crucial dimensions of status? Do not such factors as race, religion, ethnic background, intelligence, etc., go to make up other dimensions of the employee status which are relevant as criteria for selection to a particular employeeship status?⁶

Thus the insecurity of the American employee may occur independently of his skill or his integrity as an employee, viz., because his being selected as an employee is dependent on other dimensions of status which determine his employeeship in the first place. There are other factors to consider; e.g., it now happens often that technological changes make certain occupations practically obsolete. Froomkin and Jaffe have recently shown that many old skills have lost their value to the modern factory.⁷ The distribution of income also causes the employee much anxiety. The income-earning capacity of individual employees is unevenly distributed because abilities are unevenly distributed; however, this is not necessarily due only to the fact that these abilities are unevenly distributed but to the fact that the *demand* for these abilities is unevenly distributed.⁸ That is, outlets (in terms of occupation) for expression of different abilities at their own levels are not available in direct proportion to the distribution of these abilities. This forces many persons to take positions for which the requirements are often below their abilities and rarely above them. In the case of employment in the professions this is especially true. Therefore, job satisfaction is rare among persons who by reason of their race, religion, or ethnic background are excluded from specific occupations for which they are best qualified and must therefore seek other kinds of employment in which their abilities are often wasted

⁵ P. Drucker, "The Employee Society," *American Journal of Sociology*, 58 (January, 1953), 358-363.

⁶ W. E. Noland and E. W. Bakke, *Workers Wanted: A Study of Employers' Hiring Policies, Preferences, and Practices* (New York: Harper, 1949). For an excellent critique of Drucker's thesis, see J. B. McKee, "Status and Power in the Industrial Community: A Comment on Drucker's Thesis," *American Journal of Sociology*, 58 (January, 1953), 364-370.

⁷ J. Froomkin and A. J. Jaffe, "Occupational Skill and Socioeconomic Structure," *American Journal of Sociology*, 59 (July, 1953), 42-48.

⁸ J. J. Spengler, "Changes in Income Distribution and Social Stratification," *American Journal of Sociology*, 59 (November, 1953), 247-259.

and forgotten. Due to the many criteria in job selection of employees by employers and the uncertainties of the supply and demand of particular kinds of abilities, the modifiability of income distribution is limited. Tinbergen⁹ suggests that income distribution will become stable only when a stable equilibrium is established between the distribution of abilities and the employment opportunities open to those abilities. The difficulty in carrying out such a proposal as that of Tinbergen brings us to the conclusion, at least for the present, that personal insecurity in our social structure is almost inevitable.

As Ruesch¹⁰ states, "Flexibility and social change are in America principal sources of insecurity, while in Europe stratification and rigidity result in frustration." Thus, whereas in Europe a man by virtue of his ascribed status is more or less forced to face reality, in America where "everybody is alike" a man in his attempt to elevate his status ignores the realities of the status he already has and becomes extremely anxious and insecure. He pays for this American myth, i.e., that "everybody is alike" and can thus achieve any status desired, in increased rates of physical and mental illness which, as we shall see later, reflect a sociopathic society.

In summary, occupational trends show that increased industrialization has made demand for nonfarm jobs greater and greater; has called for new skills at the expense and exclusion of older skills; has increased the hiring standards for employees, i.e., the requirements of training and experience; has made the employee-status extremely significant in understanding the whole structure of our society; has caused much personal insecurity because employment is related to many factors over which the individual or society seems to have little control.

The majority of previous studies in which the problem of occupation and mental illness was directly or indirectly considered have arrived at the general conclusion that there exists an inverse relationship between the incidence or prevalence of mental illness and socio-economic status.¹¹ The main weaknesses of these studies

⁹ J. Tinbergen, "Some Remarks on the Distribution of Labour Incomes," *International Economic Papers*, I (1951), 195-207.

¹⁰ J. Ruesch, "Social Technique, Social Status, and Social Change in Illness," in C. Kluckhohn and H. A. Murray (eds.), *Personality in Nature, Society, and Culture* (New York: Knopf, 1948), 117-130.

¹¹ See C. Landis and J. D. Page, *Modern Society and Mental Disease* (New York: Farrar and Rinehart, 1938); R. E. L. Faris and H. W. Dunham, *Mental Disorders in Urban Areas* (Chicago: University of Chicago Press, 1939); E.

were as follows: (1) They dealt mainly with mental illness in general terms, and where specific mental illnesses were considered only a few of the major psychoses, such as schizophrenia, manic-depressive psychosis, and alcoholic psychosis were studied; (2) They dealt with the mentally ill as a "sexless" population, and where sex was considered studied almost exclusively males; (3) They dealt largely with urban patients; (4) Their case-finding methods were questionable and for that reason the prevalence of such mental illnesses as manic-depressive psychosis was exaggerated.¹² The main value of these studies lies in the fact that they

R. Mowrer, "A Study of Personal Disorganization," *American Sociological Review*, 4 (August, 1939), 475-487; C. Tietze, P. Lemkau, and M. Cooper, "Schizophrenia, Manic-Depressive Psychoses, and Socio-Economic Status," *American Journal of Sociology*, 47 (1941), 167-175; C. Tietze, P. Lemkau, and M. Cooper, "Personality Disorder and Spatial Mobility," *American Journal of Sociology*, 48 (July, 1942), 29-39; C. W. Schroeder, "Mental Disorders in Cities," *American Journal of Sociology*, 48 (July, 1942), 40-47; R. E. L. Faris, "Demography of Urban Psychotics with Special Reference to Schizophrenia," *American Sociological Review*, 3 (April, 1938), 203-209; R. E. Clark, "The Relationship of Schizophrenia to Occupational Income and Prestige," *American Sociological Review*, 13 (June, 1948), 325-330; R. E. Clark, "Psychoses, Income, and Occupational Prestige," *American Journal of Sociology*, 54 (1949), 433-40; S. A. Queen, "The Ecological Studies of Mental Disorder," *American Sociological Review*, 5 (April, 1940), 201-209; H. W. Dunham, "The Ecology of Functional Psychoses in Chicago," *American Sociological Review*, 2 (August, 1937), 467-479; M. Krout, "A Note on Dunham's Contribution to the Ecology of Functional Psychoses in Chicago," *American Sociological Review*, 3 (April, 1937), 209-212; R. M. Frunikin, *op. cit.*; A. B. Hollingshead and F. C. Redlich, "Social Structure and Psychiatric Disorders," *American Journal of Psychiatry*, 109 (April, 1953), 729-734; A. B. Hollingshead and F. C. Redlich, "Social Stratification and Psychiatric Disorders," *American Sociological Review*, 18 (April, 1953), 163-169; (No. 7 in this volume.) A. W. Stearns and A. D. Ullman, "One Thousand Unsuccessful Careers," *American Journal of Psychiatry*, 105 (1949) 801-811; W. M. Fuson, "Research Note: Occupation of Functional Psychotics," *American Journal of Sociology*, 48 (1943), 612-613.

¹²It is known that many private psychiatric hospitals and clinics give the more favorable diagnosis of manic-depressive psychosis to patients who, if they had been admitted to State mental hospitals, would have been given the less favorable diagnosis of schizophrenia. According to the National Association of Mental Health, about 97 per cent of all mental hospital beds are in public mental hospitals; about three per cent are in private mental hospitals. Most civil hospitals use uniform standards of diagnostic classification; this is not necessarily true of private mental hospitals. Therefore, there are less likely to be discrepancies in the diagnoses of patients in civil mental hospitals than there are in private ones. See the National Association of Mental Health's *Facts and Figures* (New York: N.A.M.H., 1952). The stand-

have called attention to the possibility that there might exist some relationship between occupation and mental illness.

METHODOLOGY

Recognizing that adequate data are not available on the relationship between occupation and major mental disorders,¹³ all first admissions with major mental disorders (1192 males and 347 females) to Ohio state prolonged-care mental hospitals for the year ended December 31, 1950, who had an occupation and who had not been classified as a housewife, student, without occupation or with an unknown occupation prior to admission, were broken down statistically, with the aid of the Bureau of Research and Statistics of the Ohio State Department of Public Welfare, by the occupational group in which their occupation belonged according to the *D. O. T.*,¹⁴ by age, by sex, and by mental disorder. Using data obtained from the 1950 census of Ohio,¹⁵ rates of first admission per 100,000 employed Ohio population were computed for the various major occupational groups by mental disorder and sex. Age-specific data were also used to determine the median ages of persons employed in different occupational groups in the normal population and median ages of persons in the mental-hospital population for the same occupational groups. These data were then used

and diagnostic manual used in most civil hospitals prior to 1952 was published by the American Psychiatric Association under the title of the *Statistical Manual for the Use of Hospitals for Mental Diseases*, Tenth Edition (Washington, D.C., 1948). The newest revision published by the A. P. A. in collaboration with the National Committee for Mental Hygiene is entitled *Diagnostic and Statistical Manual: Mental Disorders* (Washington, D.C., 1952). These Manuals are used by the Ohio State Dept. of Public Welfare's Bureau of Research and Statistics and all state mental hospitals in Ohio.

¹³ Major mental disorders include the most common mental illnesses, i.e., those with the highest incidence, viz., syphilitic psychosis, alcoholic psychosis, psychosis with cerebro-arteriosclerosis, senile psychosis, involutional psychosis, manic-depressive psychosis, schizophrenia, psychoneurosis, and alcoholism without psychosis. The diagnostic classification of mental illness used by Ohio State mental hospitals was based on the following source: American Psychiatric Association, *Statistical Manual for the Use of Hospitals for Mental Diseases*, Tenth Edition (Washington, D.C., 1948).

¹⁴ U. S. Department of Labor, *Dictionary of Occupational Titles*. Second Edition. Vols. I and II (Washington, D.C., 1949).

¹⁵ U. S. Census of Population: 1950, *General Characteristics of Ohio*. Report P-B35. (Washington, D.C., 1952); *ibid.*, *Detailed Characteristics of Ohio*. Report P-C35. (Washington, D.C., 1952.)

for comparative analysis of the two populations with respect to the factors of unemployment, income, education, and other relevant data obtained from the 1950 Ohio census previously noted and other sources.

FINDINGS

Most of the basic statistical data in this study are summarized in Tables 1-4. A review of the major findings follows.

OCCUPATION AND MAJOR MENTAL DISORDERS

(See Tables 1 and 2)

1. PROFESSIONAL (AND SEMI-PROFESSIONAL) GROUP

(a) *Male*. Male professional workers ranked eleventh, or next to the lowest, in rates of first admissions. Within this group, schizophrenia was the highest-ranking mental illness with a rate of 7.2 per 100,000 employed population; psychosis with cerebro-arteriosclerosis and alcoholic psychosis ranked second and third with rates of 6.6 and 3.0 respectively. There were no cases of syphilitic or involutional psychosis reported in this group.

(b) *Female*. Professional female admissions ranked seventh in rates of first admissions. Within this group, involutional psychosis was the leading mental illness with a rate of 8.3; schizophrenia ranked second with a rate of 6.2; and psychosis with cerebro-arteriosclerosis and manic-depressive psychosis were tied for third with a rate of 4.2. There were no cases of syphilitic psychosis or psychoneurosis reported for this group.

2. MANAGERIAL GROUP

(a) *Male*. Among all occupational groups, the managerial group had the lowest rate of first admissions, 19.1 per 100,000. Within this group, three mental illnesses were tied for top ranking, viz., alcoholic, senile, and manic-depressive psychosis with a rate of 2.7 per 100,000 employed Ohio population. The managerial group had the lowest rates of schizophrenia and psychosis with cerebro-arteriosclerosis.

(b) *Female*. This group ranked eighth among all occupational groups in rates of first admissions. The leading mental illness in this group was schizophrenia with a rate of 12.6 per 100,000. They

TABLE 1. RATES OF FIRST ADMISSION FOR MAJOR OCCUPATIONAL GROUPS, BY
MENTAL DISORDER, MALE: 1950
(Rates in terms of 100,000 employed persons according to the 1950 census of Ohio)

Occupational Group	Mental Disorder									
	Total	Syphilitic Psychosis	Alcoholic Psychosis	Psychosis with Cerebro-arterio-sclerosis	Senile Psycho- chosis	Involuntal Psychosis	Manic- Depressive Psychosis	Schizo- phrenia	Psycho- neurosis	Alcoholism without Psychosis
Professional and										
Semi-professional	22.8	0.0	3.0	6.6	1.2	0.0	2.4	7.2	0.6	1.8
Managerial	19.1	1.8	2.7	1.4	2.7	1.4	2.7	2.3	2.3	1.8
Clerical	32.1	1.9	3.8	3.2	3.2	1.3	2.6	13.5	1.3	1.3
Sales	36.1	2.1	7.1	7.1	2.1	0.0	2.1	8.5	4.3	2.8
Domestic Service	64.0	0.0	0.0	32.0	0.0	0.0	0.0	32.0	0.0	0.0
Personal Service	104.5	11.8	11.8	23.7	9.9	3.9	7.9	13.8	11.8	9.9
Protective Service	61.5	0.0	6.5	29.1	6.5	0.0	6.5	12.9	0.0	0.0
Building Service	67.1	5.1	0.0	16.1	5.4	2.7	8.0	21.4	2.7	5.4
Agricultural	81.5	2.1	1.1	22.6	17.9	5.8	6.3	22.6	0.5	2.6
Skilled	47.9	4.1	8.0	11.6	5.1	2.0	2.2	9.2	1.6	4.1
Semi-skilled	30.7	3.8	5.3	4.6	1.8	1.8	1.6	8.8	1.5	1.5
Unskilled	201.9	19.4	22.8	43.9	13.7	10.8	7.4	67.3	6.3	10.3

had relatively low rates of admission in other major mental disorders.

3. CLERICAL GROUP

(a) *Male.* Male clerical workers ranked ninth in rates of admissions. Within this group, schizophrenia was by far the leading mental illness with a rate of 13.5; alcoholic psychosis ranked second with a rate of 3.8, and the psychoses of old age were tied for third with a rate of 3.2 each.

(b) *Female.* This group ranked sixth in rates of first admissions. Schizophrenia, as in the case of male clerical workers, was by far the leading mental illness with a rate of 17.2; manic-depressive psychosis and psychoneurosis were tied for second with a rate of 2.9 per 100,000 employed Ohio population.

4. SALES GROUP

(a) *Male.* This group ranked eighth in rates of first admissions. Schizophrenia was the leading mental illness within this group with a rate of 8.5; alcoholic psychosis and psychosis with cerebro-arteriosclerosis were tied for second with a rate of 7.1.

(b) *Female.* Sales workers ranked ninth in rates of first admissions. Within this group, schizophrenia was the highest-ranking mental illness with a rate of 6.1 per 100,000; involutional psychosis was second with a rate of 3.6, and psychosis with cerebro-arteriosclerosis was third with a rate of 2.4.

5. DOMESTIC SERVICE GROUP

(a) *Male.* There were relatively insufficient data on male domestic workers but the little data available indicate that their rates of admission correspond in type to those of other service workers.

(b) *Female.* Almost one-third of all employed female first admissions were domestic workers. They had the second highest rate of first admissions. Within this group, the leading mental illness was schizophrenia with a rate of 57.7 per 100,000; the psychoses of old age (i.e., senile psychosis and psychosis with cerebro-arteriosclerosis) ranked second and third. They had the highest rate of alcoholic psychosis.

TABLE 2. RATES OF FIRST ADMISSION FOR MAJOR OCCUPATIONAL GROUPS, BY
MENTAL DISORDER, FEMALE: 1950
(Rates in terms of 100,000 employed persons according to the 1950 census of Ohio)

Occupational Group	Mental Disorder									
	Total	Syphilitic Psychosis	Alcoholic Psychosis	Psychosis with Cerebro-arterio-sclerosis	Senile Psychosis	Involuntal Psychosis	Manic-Depressive Psychosis	Schizo-phrenia	Psycho-neurosis	Alcoholism without Psychosis
Professional and										
Semi-professional	25.9	0.0	1.0	4.2	1.0	8.3	4.2	6.2	0.0	1.0
Managerial	19.0	3.2	0.0	0.0	0.0	0.0	3.2	12.6	0.0	0.0
Clerical	29.7	0.8	1.7	0.8	1.7	1.3	2.9	17.2	2.9	0.4
Sales	14.5	0.0	0.0	2.4	1.2	3.6	0.0	6.1	1.2	0.0
Domestic Service	204.7	22.3	20.5	40.9	27.9	14.9	14.9	57.7	3.7	1.9
Personal Service	49.0	2.9	2.9	4.9	5.9	2.0	3.9	21.6	3.9	1.0
Protective Service	00.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Building Service	59.4	9.9	0.0	9.9	29.7	0.0	0.0	9.9	0.0	0.0
Agricultural	13.2	0.0	0.0	0.0	0.0	6.6	0.0	6.6	0.0	0.0
Skilled	150.5	0.0	6.5	39.3	32.7	13.1	0.0	58.9	0.0	0.0
Semi-skilled	4.3	0.0	0.0	1.2	0.6	0.0	0.6	1.9	0.0	0.0
Unskilled	472.4	40.5	0.0	40.5	0.0	27.0	54.0	283.4	27.0	0.0

6. PERSONAL SERVICE

(a) *Male*. Male personal-service workers had the second highest rate of first admissions. Within this group, psychosis with cerebro-arteriosclerosis ranked first with a rate of 23.7; schizophrenia was second with a rate of 13.8, and three mental illnesses were tied for third, viz., alcoholic psychosis, syphilitic psychosis, and psychoneurosis, each with a rate of 11.8 per 100,000. Personal-service workers had the highest rate of psychoneurosis.

(b) *Female*. This group ranked fifth in rates of first admissions. By far, the leading mental illness within this group was schizophrenia with a rate of 21.6 per 100,000. The psychoses of old age ranked second and third.

7. PROTECTIVE SERVICE

(a) *Male*. These workers ranked sixth in rates of first admissions. Within this group, psychosis with cerebro-arteriosclerosis was first with a rate of 29.1 per 100,000; schizophrenia ranked second with a rate of 12.9; and alcoholic, senile, and manic-depressive psychoses ranked third each with a rate of 6.5. Protective workers ranked lowest in syphilitic and involutional psychoses, psychoneurosis, and alcoholism without psychosis.

(b) *Female*. There were no female first admissions with protective service occupations.

8. BUILDING SERVICE

(a) *Male*. Building-service workers ranked fourth in rate of first admissions. Within this group, schizophrenia was the leading mental illness with a rate of 21.4 per 100,000; psychosis with cerebro-arteriosclerosis ranked second with a rate of 16.1, and manic-depressive psychosis was third with a rate of 8.0. This group had one of the lowest rates of alcoholic psychosis but the highest rate of manic-depressive psychosis.

(b) *Female*. This group ranked fourth in rates of first admissions. Within this group, senile psychosis was by far the leading mental illness with a rate of 29.7 per 100,000; schizophrenia, syphilitic psychosis, and psychosis with cerebro-arteriosclerosis were tied for second with a rate of 9.9 each. These workers had relatively low rates of admission in all other major mental disorders.

9. AGRICULTURAL GROUP

(a) *Male*. These workers ranked third in rates of first admissions. Within this group, two mental illnesses ranked first each with a rate of 22.6 per 100,000, viz., schizophrenia and psychosis with cerebro-arteriosclerosis; senile and manic-depressive psychosis ranked second and third with rates of 17.9 and 6.3 respectively. They had one of the lowest rates of psychoneurosis.

(b) *Female*. The number of first admissions from this occupational group was relatively insignificant.

10. SKILLED GROUP

(a) *Male*. Skilled workers ranked seventh in rates of first admissions. Within this group, psychosis with cerebro-arteriosclerosis ranked first with a rate of 11.6 per 100,000; schizophrenia was second with a rate of 9.2, and alcoholic psychosis was third with 8.0.

(b) *Female*. These workers ranked third in rates of first admissions. Within this group, schizophrenia ranked first with a rate of 58.9; the psychoses of old age ranked second and third. These workers had moderate rates in most of the remaining mental illnesses.

11. SEMI-SKILLED GROUP

(a) *Male*. These workers ranked tenth in rates of first admissions. Their leading mental illness was schizophrenia with a rate of 8.8 per 100,000; alcoholic psychosis was second with a rate of 5.3, and psychosis with cerebro-arteriosclerosis was third with a rate of 4.6.

(b) *Female*. These workers, as did male semi-skilled workers, ranked low in rates of first admissions—eleventh. The leading mental illness in this group was schizophrenia with a rate of 1.9 per 100,000 employed Ohio population.

12. UNSKILLED GROUP

(a) *Male*. This group had the highest rate of mental illness, 201.9 per 100,000. They had the highest rate of first admissions in practically all mental disorders. Within this group, schizophrenia was the leading mental illness with a rate of 67.3 per 100,000 employed Ohio population; psychosis with cerebro-arteriosclerosis was sec-

ond with a rate of 43.9, and alcoholic psychosis was third with a rate of 22.8.

(b) *Female*. Unskilled workers were also the highest in rate of first admissions among females. The leading mental illness within this group was schizophrenia with a rate of 283.4 per 100,000, manic-depressive psychosis ranked second with a rate of 54, and syphilitic psychosis and psychosis with cerebro-arteriosclerosis were tied for third with a rate of 40.5.

AGE, OCCUPATION, AND MAJOR MENTAL DISORDERS

(See Tables 3 and 4)

The median ages of first admissions to mental hospitals with particular mental disorders are rather constant. Thus among the major mental disorders we find such illnesses as schizophrenia and psychoneurosis usually occurring between the ages of 18 and 50; alcoholism with and without psychosis, syphilitic psychosis, manic-depressive psychosis, and involutional psychosis generally occurring during middle age, i.e., from 35-55; and senile psychosis and psychosis with cerebro-arteriosclerosis (both often called collectively the "psychoses of old age") usually occurring about or after age 55.

Since age is directly related to the type of mental disorder an individual may become affected with, one would expect to find, and one does find, that occupational groups in the employed population which have low median ages have high rates of admission for those mental disorders which are characteristic of younger age groups, and that those occupational groups with high median ages have high rates of admission for those mental disorders which are characteristic of older age groups. Thus, for example, we find that among female clerical workers whose median age in the employed population was 29.4 years, that the highest-ranking mental illness is schizophrenia (median age of admissions 29.0). In the census of mental patients in 1949, the median age of female first admissions with schizophrenia was 33.3 years.¹⁰ Let us take another example. In the employed male population in Ohio in 1950, protective-service workers had one of the highest median ages of all major occupational groups, viz., 47.7 years. The leading mental illness in this group was psychosis with cerebro-arteriosclerosis (median

¹⁰ National Institute of Mental Health, *Patients in Mental Institutions: 1949* (Washington, D. C., 1952). See page 41.

TABLE 3. MEDIAN AGES OF FIRST ADMISSIONS AND EMPLOYED OHIO POPULATION,
BY OCCUPATION, BY MENTAL DISORDER, MALE: 1950

Occupational Group	Employed Population	Mental Disorder								
		Syphilitic Psychosis	Alcoholic Psychosis	Psychosis with Cerebro-arterio-sclerosis	Senile Psychosis	Involuntional Psychosis	Manic-Depressive Psychosis	Schizophrenia	Psychoneurosis	Alcoholism without Psychosis
Professional and Semi-professional	39.1	•	42.3	65+	65+	•	50.0	35.0	55.0	33.7
Managerial	44.0	57.5	45.0	65+	65+	57.5	55.0	40.0	42.5	51.6
Clerical	37.0	50.0	51.6	65+	65+	57.5	50.0	34.5	25.0	32.0
Sales	36.6	50.0	47.0	65+	65+	•	50.0	37.5	25.0	40.0
Domestic Service	46.9	•	•	65+	•	•	•	35.0	•	•
Personal Service	38.0	50.0	45.0	62.5	65+	60.0	30.0	32.5	35.0	46.6
Protective Service	47.7	•	60.0	65+	65+	•	45.0	40.0	•	•
Building Service	52.3	50.0	•	65+	65+	50.0	50.0	33.8	30.0	49.5
Agricultural	45.9	50.0	35.0	65+	65+	59.0	50.0	35.0	45.0	43.3
Skilled	41.4	46.5	47.8	65+	65+	55.0	36.6	35.0	30.0	47.5
Semi-skilled	36.5	49.5	43.6	65+	65+	55.0	37.5	34.9	30.0	42.5
Unskilled	37.4	49.2	40.3	65+	65+	58.2	42.5	29.0	29.5	41.6
All Groups	40.0	50.0	44.0	65+	65+	58.6	45.8	32.7	32.5	44.3

• Insufficient data.

age of admissions was 65+). In the U.S. census of mental patients in 1949, the median age of admissions with psychosis with cerebro-arteriosclerosis was 70+.¹⁷

Nevertheless it is evident that patients admitted to mental hospitals are relatively older; in most instances, than the employed population. The exceptions occur in the case of schizophrenia and psychoneurosis, since first admissions with these mental illnesses usually have median ages between 30 and 38 whereas the median age of the employed population among male employees was 40 years and among female employees 36.3 years.

DISCUSSION

Let us suggest, on the basis of our findings, that (a) there seems to exist a group differential in the rates of first admissions which is inversely related to the factors of income, prestige, and socio-economic status as they are manifested in occupation; and (b), although age is directly related to the type of mental illness an individual might become affected with, age alone does not account for the fact that persons from different occupational groups seem to have a differential propensity for particular types of major mental disorders.

Thus, in accordance with hypothesis (a), persons in such occupational groups as those composed of unskilled and service workers—i.e., occupations which reflect low income, prestige, and socio-economic status—were found to have the highest rates of first admissions with major mental disorders, and conversely, persons in high status and managerial occupations had the lowest rates. The fact that syphilitic and alcoholic psychoses have their highest rates of first admissions in low-status occupational groups rather than higher-status groups supports the validity of hypothesis (b).

Although occupation is not considered by some sociologists as a totally satisfactory index of social class, many agree, however, that it is nevertheless a usable and valid index of social class.¹⁸ Lastrucci has done an excellent analysis of occupational research,¹⁹

¹⁷ *Ibid.*, see page 40.

¹⁸ See P. K. Hatt, "Occupation and Social Stratification," *American Journal of Sociology*, 55 (May, 1950), 533-543; also, T. Parsons, "An Analytical Approach to the Theory of Social Stratification," *American Journal of Sociology*, 46 (May, 1940), 841-862.

¹⁹ C. L. Lastrucci, "The Status of Occupational Research," *American Sociological Review*, 11 (February, 1946), 78-84.

TABLE 4. MEDIAN AGES OF FIRST ADMISSIONS AND EMPLOYED OHIO POPULATION,
BY OCCUPATION, BY MENTAL DISORDER, FEMALE: 1950

Occupational Group	Employed Population	Mental Disorder								
		Syphilitic Psychosis	Alcoholic Psychosis	Psychosis with Cerebro-arterio-sclerosis	Senile Psychosis	Involuntional Psychosis	Manic-Depressive Psychosis	Schizophrenia	Psychoneurosis	Alcoholism without Psychosis
Professional and Semi-professional	34.5	•	50.0	65+	65+	51.6	35.0	40.0	•	39.0
Managerial	44.4	50.0	•	•	•	•	40.0	33.3	•	•
Clerical	29.4	45.0	50.0	65+	65+	47.5	40.0	29.0	28.1	40.0
Sales	36.4	•	•	65+	65+	47.5	•	40.0	20.0	•
Domestic Service	42.6	40.0	43.0	65+	65+	51.0	44.0	34.2	42.0	32.5
Personal Service	38.0	57.5	57.5	65+	65+	45.0	40.0	33.3	32.5	38.0
Protective Service	•	•	•	•	•	•	•	•	•	•
Building Service	41.3	50.0	•	62.5	65+	•	•	55.0	•	•
Agricultural	44.6	•	•	•	•	50.0	•	45.0	•	•
Skilled	40.6	•	40.0	65+	65+	52.5	•	37.5	•	•
Semi-skilled	36.9	•	•	64.5	65+	•	50.0	32.5	•	•
Unskilled	35.9	37.5	•	65+	•	60.0	37.5	31.5	25.0	•
All Groups	36.3	42.8	46.6	65+	65+	51.0	42.5	33.3	29.2	38.3

• Insufficient data.

both existing and needed research, but as his study indicates, research as specifically related to the problem of occupation and mental illness is limited. Yet, when one considers the dimensions of occupation, i.e., in terms of duties, prerequisites, and rewards, it is possible not only to conceive of *occupation* as a usable and valid index of social class, but as *one of the very best indices of social class*. In the most recent studies of social class and mental illness, Hollingshead and Redlich²⁰ developed an Index of Social Position²¹ in which factor weights for that scale were as follows: occupation, 8; education, 6; and residence, 5. The fact that Hollingshead and Redlich gave occupation the highest weight in their Index lends support to the writer's latter contention.

Thus far, in this study, the importance of the factors of income and prestige as manifested in occupation, as in many other studies, is imputed on the basis of the method of *Verstehen*,²² rather than by strictly empirical methods. If we correlate²³ the rates of first admission with income and prestige we find that our *Verstehen* hypotheses seem more valid with respect to male than to female first admissions.²⁴ The following correlations illustrate this point:

<i>Factors Correlated</i>	<i>Male</i>	<i>Female</i>
Income and Prestige	.90	.74
Rates of Admission and Prestige	.81	.53
Rates of Admission and Income	.71	.15

²⁰ A. B. Hollingshead and F. C. Redlich, *American Sociological Review*, *op. cit.*

²¹ A detailed statement of this Index will be described in a forthcoming monograph tentatively entitled *Psychiatry and Social Class* by A. B. Hollingshead and F. C. Redlich.

²² R. Redfield, "The Art of Social Science," *American Journal of Sociology*, 54 (1948), 181-191.

²³ Correlations are based on the Spearman Rank-Order Correlation

$$\rho(\text{rho}) = 1 - \frac{6 \sum D^2}{N(N^2 - 1)}$$

See F. E. Croxton and D. J. Cowden. *Applied General Statistics* (New York: Prentice-Hall, 1945), 685-686.

²⁴ Median income for the various occupational groups were obtained from the 1950 census data on Ohio (see footnote 15). The prestige rankings of occupational groups were based on a composite rating developed by the writer from the following studies: G. S. Counts, "The Social Status of Occupations," *School Review*, 33 (1925), 16-27; J. A. Nietz, "The Depression and the Social Status of Occupations," *Elementary School Journal*, 35 (1935), 454-461; M. Smith, "An Empirical Scale of Prestige Status of Occupations," *American*

Therefore, in this study, we find that prestige and income are more closely related to the rates of male first admissions, by occupation, than they are to rates of female admissions. This leads to a tentative verification of a *Verstehen* hypothesis which, I am sure, many social scientists as well as lay persons have made, viz., *that a man's occupation, in general, is more important to his mental health than is the occupation of a woman to her mental health*. In other words, whereas a job to most men is their means to ego satisfaction, i.e., the way in which they preserve their personal integrity and maintain a place in the world for themselves, in the case of most women the goal of ego satisfaction is achieved through their status as wife, mother, or through the status of their husbands, rather than through a job other than that of "housewife." The low correlations of income and prestige with the rates of female admissions lends validity to the latter hypothesis.

Furthermore, an examination of these correlations seem to indicate that *prestige is more important to mental health than income in the case of both male and female admissions*.²⁵ Thus our earliest tentative hypothesis must be restated in ten more specific hypotheses, viz:

1. There is an inverse relationship between rates of first admissions and income and prestige as manifested in occupation *but* there are definite sex differences in this relationship which indicate that occupation is generally more important to the mental health of men than of women.
2. Occupational prestige is more significant to mental health than is occupational income.
3. Occupational income is more significant to the mental health of men than of women, probably because occupation is not the only source of income for women.
4. Because occupational income and prestige are considered as valid indices of socio-economic status, it can be stated that rates of admission, in general, are inversely related to socio-economic status.

Let us now consider the earlier tentative hypothesis (b), stated at the beginning of this discussion: i.e., that age alone does not account for the fact that persons from different occupational groups seem to have a differential propensity for particular types

Sociological Review, 8 (April, 1943), 185-192; C. C. North and P. K. Hatt, "Jobs and Occupations: A Popular Evaluation," in L. Wilson and W. L. Kolb (eds.), *Sociological Analysis* (New York: Harcourt, 1946), 464-474.

²⁵ See R. Hoppock, *Job Satisfaction* (New York: Harper, 1935).

of major mental disorders. We have already seen in hypotheses 1-4, that occupational income and prestige account, in part, for these differential rates of admission by occupation. However, the work of Centers²⁶ and Parsons²⁷ suggest that there are psychological and social factors which might explain, in part, why persons of different occupational groups seem to have a propensity for particular types of mental disorders. Centers found that radicalism, in terms of attitudes toward social, economic, and political issues, is inversely related to socio-economic status as manifested in occupation. Thus, he found that laboring groups are conspicuously non-conservative, the middle class conservative, and the upper class ultraconservative. This might explain, to some degree, why rates of syphilitic and alcoholic psychosis are relatively higher in the laboring groups.

But sex, in terms of social roles, is also important for our understanding of differential rates of mental illness. Parsons therefore states that "It is of fundamental significance to the sex role structure of the adult age levels that the normal man has a 'job' which is fundamental to his social status in general. It is perhaps not too much to say that only in very exceptional cases can an adult man be genuinely self-respecting and enjoy a respected status in the eyes of others if he does not 'earn a living' in an approved occupational role. Not only is this a matter of his own economic support but, generally speaking, his occupational status is the primary source of income and class status of his wife and children."²⁸ The meaning of occupation for the female, as indicated earlier, is not the same. Thus, we find that the more radical male and female unskilled and service workers have the highest rates of alcoholic and syphilitic psychosis because, next to criminal acts, sexual promiscuity and alcoholism seem to be the best emotional outlets, the best-known escape, from the hostility, the rejection, and general frustration which are so often encountered by people in the lower socio-economic strata of our society. The lower-class man thus "proves" that he is a man by engaging in sexual relations with as many different women as possible, and by overindulging in alcoholic beverages, a lower-class man's way of

²⁶ R. Centers, *The Psychology of Social Classes* (Princeton: Princeton University Press, 1949).

²⁷ T. Parsons, "Age and Sex in the Social Structure of the United States," *American Sociological Review*, 7 (October, 1942), 604-616.

²⁸ T. Parsons, *ibid.*, p. 609.

drowning his sorrows. The lower-class woman is more than likely to share his attitudes but participate in such activities on a relatively smaller scale.

It is suggested that such mental disorders as alcoholic and syphilitic psychosis occurring most frequently among radical *lower-class* occupational groups are oriented by those affected *against society and its mores*, whereas mental disorders such as manic-depressive psychosis, involutional psychosis, schizophrenia, and psychoneurosis, occurring relatively more among conservative *upper classes* than the former mental disorders, are oriented not necessarily against a society but mainly against the *self*. Thus the action taken by lower-class persons in response to the frustration of ego satisfaction is directed against society, since society is the authoritative figure which they believe has been working against them. In the conservative upper classes, the individual is not consciously against society, and therefore generally, consciously or unconsciously, turns against himself, and perhaps unconsciously against society. This same rationale might be applied to an understanding of crime. Upper-class, "white-collar crime" is generally more a personal matter, whereas laboring-class crimes are more or less directed against society. To go a step farther, one might say that the etiology of lower socio-economic-status-group mental illness (and crime) is generally sociogenic in nature, whereas in the upper strata of society, mental illness is generally more psychogenic. Thus, the etiology of middle-class mental disorders, being somewhere in between, i.e., more or less equally sociogenic and psychogenic, or simply *social-psychogenic*, in origin, reflects characteristics of both the extreme strata of society. Since women as a group are more conservative than men one would expect to find that their rates of admission in the more psychogenic mental illnesses are higher than the rates for the more radical male first admissions. This was found to be the case. Females had higher rates of involutional psychosis, manic-depressive psychosis, and psychoneurosis than men. Males had higher rates of syphilitic and alcoholic psychosis than women.

Several hypotheses, tentative in nature, follow the foregoing discussion:

5. Radical lower-class occupational groups have high rates of admission for mental disorders which are largely sociogenic in origin, i.e., due to sociopathy, and are thus generally oriented against society.

6. Ultraconservative upper-class occupational groups have higher rates of admission for mental disorders which are largely psychogenic in origin, i.e., due to psychopathy, and are thus generally oriented against the self.

7. Conservative middle-class occupational groups are thus affected with mental disorders which reflect rather equally both the sociogenic and psychogenic nature of mental illness, and are more or less social-psychogenic in origin, and consequently directed both against society and the self.

8. Since men as a group are more radical than women, their rates of admission for particular mental illnesses tend to correspond more closely to lower-class patterns of mental illness.

9. Since women as a group are thus more conservative than men, their rates for particular mental illnesses tend to correspond more closely to upper-class patterns of mental illness.

10. Any individual who by reason of social class or sex, or who by reason of adopting the social psychology of a particular social class or sex, even though it may not be his own, tends to be prone to particular types of mental disorders which are characteristic of that class or sex. Thus, for example, effeminate, artistic men, regardless of class, are more likely to become psychoneurotic (a "high-class feminine mental illness") than, for example, professional, masculine career women.

The factor of unemployment is also important to consider. Rank-order correlations between unemployment and rates of first admission by occupation, were as follows: for males, .66, and for females, .19. Thus, the fact that the greatest amount of unemployment, in 1950, was in the lowest-income occupations explains, in large part, why men upon whose occupation ego satisfaction is usually dependent have rates of mental illness which are more directly related to unemployment than the rates of admission among females.²⁹ Also, since older persons have difficulties obtaining positions it is now understandable why the median age of first admissions to mental hospitals, except in the case of those with schizophrenia and psychoneurosis, is higher than the median age in the normal employed population.

There are, of course, other aspects of the problem of occupation and mental illness which should be considered but which do not permit discussion because of the limits of space and of the

²⁹ P. Eisenberg and P. F. Lazarsfeld, "The Psychological Effects of Unemployment," *Psychological Bulletin*, 35 (1938), 358-390.

scope of this inquiry. However, the writer feels it his duty to mention at least three more factors which, it is strongly believed, indirectly seem to bear crucial significance to the whole problem, viz., *education, intelligence, and population trends.*

Education is one of the most closely related factors affecting socio-economic status. As mentioned earlier, hiring standards for jobs have increased in terms of the requirements of education or its equivalent in training. Vocational choice and preparation should thus be the major concern of every young person, especially young men. But, although young people are concerned with the problem of vocational selection, our educational system, for the most part, impedes rather than facilitates their making a wise choice. In 1950, only about 7 per cent of all employed workers were classified in professional and semi-professional occupations. Yet, in a recent study of the vocational interests of high-school students, more than 60 per cent expressed their desire to enter professional and semi-professional occupations.³⁰ Because an individual's intelligence is an important criterion of his probable vocational success in many occupations,³¹ our educational system should prepare our young people realistically in terms of their mental abilities and interests. If more than 60 per cent of our high-school students select professional occupations as their vocational objectives it is evident that our education system is not meeting the need for wise vocational choice effectively. In an attempt to educate everyone in terms of middle-class values, the result is that persons who would be more successful in non-professional occupations (which make up about 93 per cent of the employed population) are not prepared for those occupations. Too many more adolescents are enrolled in college-preparatory curricula than there should be. It would be better for the mental health of the American people if we, as the British have done so effectively, were to guarantee every child eight years of education in grammar school in order to learn the basic elements of reading, writing, and arithmetic, and other arts and sciences, and then, on the basis of ability (and interest) send each child to the kind of school which would prepare him realistically for the occupation he can be most successful in. The fact that almost every American child is

³⁰ W. A. Bradley, "Correlates of Vocational Preferences," *Genetic Psychology Monographs*, 28 (1943), 99-169.

³¹ I. Lorge and R. Blau, "Broad Occupational Groups by Intelligence Levels," *Occupations*, 20 (March, 1942), 419-423.

treated as if he had the same ability as all other children is the fallacy in our educational system which causes the dull and the bright child, as well as the average child, to suffer the consequences of an unrealistic and wasteful kind of education which in the end results in no child getting a good education.

Realizing the defects of our educational system, the state of New York has initiated some special programs of education to meet the needs of children of different abilities. Thus there are trade and industrial schools for those children who shall benefit most from them; there are science-specialized high schools for children who show promise in scientific, engineering, and other technological vocations; there are high schools for students who show talents in the fine arts—music, painting, dramatics, etc.; and there are general college-preparatory high schools for students who show promise of benefiting by higher education. These schools are few in comparison to the old types of high schools, but they represent a move in the right direction.

Population trends are another factor that must be considered. America, as well as the rest of the world, is becoming too heavily populated. The high birth rate among the families who can least afford to raise children in terms of minimum standards of health and decency is by far one of the greatest single threats to peace, to mental and physical health, and to world security.³² Planned parenthood could help very much to free the world from many of its existing evils.³³ Overpopulation is the source of much of the poverty, crime, unemployment, war, social disorganization, and mental illness that presently persist on this earth. The human misery caused by overpopulation is, in the writer's opinion, one of the basic factors in the acceptance and growth of totalitarian philosophies throughout the world. In short, the acceptance of Communism is, in large part, the result of uncontrolled human reproduction.

SUMMARY AND CONCLUSIONS

In summary, we find that the basic hypothesis suggested earlier in this study—that there is a group differential in the rates of first

³² G. I. Burch and E. Pendell, *Population Roads to Peace or War* (Washington, D. C., Population Reference Bureau, 1945).

³³ A. Stone, "Planned Parenthood Around the World," *Marriage and Family Living*, 15 (May, 1953), 98-101.

admissions which is inversely related to the factors of income, prestige, and socio-economic status as these factors are manifested in occupation—can be held tentatively as being of some validity. The validity of this hypothesis is evidenced in the high incidence of mental illness among low-income, low-prestige, and low-socio-economic-status groups as shown by this study of first admissions to Ohio state mental hospitals in the year ended December 31, 1950.

From our findings other hypotheses have resulted and have been suggested. Thus, it has been suggested that occupational prestige is more significant to mental health than is occupational income; that occupational income is more significant to the mental health of men than of women; that age alone does not account for the differential rates of admission in different occupational groups; that lower-class occupational groups develop mental illnesses which are largely sociogenic in origin; that upper-class occupational groups develop mental illnesses which are largely psychogenic in origin; that middle-class occupational groups develop mental illnesses which reflect equally both sociogenic and psychogenic origins, and hence may be thought of as largely social-psychogenic; that the mental illnesses of men correspond to those of the lower-class occupational groups; that the mental illnesses of women correspond to those of the upper-class occupational groups; that rates of unemployment are directly related to rates of admission; and finally, that any individual, by reason of social class or sex, or by reason of adopting the social psychology of a particular class or sex, even though it may not be his own, shall be prone to particular types of mental illnesses which are characteristic of that social class or sex.

This study rejects Krout's contention³⁴ that sex, on the basis of Dunham's studies,³⁵ is not significant in the etiology of mental illness. Rather, this study suggests that sex is an extremely important factor in mental illness, regardless of the fact that in the majority of previous studies it has been almost totally neglected.

It is also suggested that our educational system because of its rejection of the truth of individual differences has helped rather than hindered vocational maladjustment, and consequently has contributed, in part, to the prevalence of mental illness.

It is also suggested that overpopulation and the rejection of the

³⁴ M. Krout, *op. cit.*

³⁵ W. H. Dunham, *op. cit.*

humaneness of planned parenthood have been basic factors in the development of some of the tensions which have resulted in mental illness and many other social problems.

In conclusion, it is suggested that while psychogenic factors are important in the development of mental illness, sociogenic factors as evidenced in the sociopathic features of our social structure are mainly responsible for growing rates of mental illness.³⁶

SUGGESTIONS FOR FURTHER RESEARCH

Since this study is largely concerned with group phenomena, and is actuarial in character, rather than individual, the next step should concern itself with a clinical study of the individual in relation to his occupation and his mental illness. This is a task for the clinician and is beyond our scope of inquiry.

However, perhaps a better method is the interdisciplinary team approach to the problem of psychiatric disorders and social class used in the recent studies of Hollingshead and Redlich.³⁷ At any rate, our findings indicate that further research on this fascinating problem of occupation and major mental disorders is certainly warranted.

³⁶ For an enlightening treatment of the subject of sociopathy see R. Bain, "The Concept of Sociopathy," *Sociology and Social Research*, 38 (September-October, 1953), 3-6.

³⁷ A. B. Hollingshead and F. C. Redlich, *American Sociological Review*, *op. cit.*

Ethnic Variations in Mental Stress in Families with Psychotic Children*

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IN THIS paper we shall report the results of research concerned with ethnic variations in mental stress observed in families with psychotic children. In view of the paramount importance of the socialization process within the family in shaping the individual into a functioning member of society, we designed a research project focusing on the dimensions of authority and solidarity within the family. Our goal was to understand the relationship between family social structure and the production of individual stress. Families belonging to various ethnic subcultures were expected to differ from one another in a way reflective of their subcultures. Therefore, we decided to see how they were different and what it was that made them different.

The ethnic¹ groups we finally chose for study are the Irish, Jewish, and Italian. As a kind of baseline for comparison, we also selected a group of families which we consider to be typically Yankee-American. The material for our research was obtained from the analysis of 69 families, 18 each in the Italian, Irish, and

* From *Social Problems* (October, 1953, 48-53). Reprinted by permission of the authors and publishers. This is a preliminary report of a two-year study financed by the Russell Sage Foundation, conducted at the Boston Psychopathic Hospital.

¹ For our purpose we define a member of an ethnic group as a person who regards himself or is regarded by others as distinguished by religion or national origin from the native-born white Protestant majority. The ethnicity of a member of an ethnic group refers to the degree to which his behavior reflects the values, language, and customs characteristic of his ethnic group. We restrict our choice to persons of lower socio-economic status whose parents were both born in rural Ireland, Southern Italy, or the semi-urban areas of Jewish settlement in Eastern Europe. A Yankee is defined as a person of Anglo-Saxon white Protestant ancestry, with native-born grandparents, who is regarded by himself and others as Yankee.

Jewish groups and 15 in the Yankee. In selecting our cases we chose patients between the ages of eighteen and thirty-five because we felt that that period of life during which the individual made his first major adjustments as an adult would be most pertinent to our interest in the relationship between stress and the social structure of the family. In general, our choice of cases was not restricted by marital status or type of diagnosis, but we tried to obtain an equal number of male and female cases in each group.

The cases admitted to the Boston Psychopathic Hospital came from many different sources. Since it is a state-supported diagnostic and treatment hospital it receives both unselected patients directly from the community and many transfers from other state hospitals. Most patients come from the Metropolitan Boston Area. We fully appreciate the geographic limitations of our sample. We assume that any one member of an ethnic group living either alone or in contact with other members of his group in other geographical areas of the United States might well experience some different stresses, or that they might at least be phrased somewhat differently.

Families of the Jewish, Irish, and Italian groups all belonged to the lower socio-economic level as determined by standard procedures. In contrast, the Yankee group belonged to the middle level. Total family membership of all groups included 439 persons.

Our basic methodological tool was a semi-structured interview which allowed the interviewee complete freedom to formulate his answers within the framework of the outline used by the interviewer. Interviews were conducted by the authors. They averaged approximately twenty hours per case. In addition to the patient, every available relative was interviewed, and full use was made of other sources of information such as doctors and social workers who, in turn, often had interviewed family members other than those contacted by the authors. Finally, case records and other pertinent documents were examined. Notes were taken at all interviews and tape recordings were made at approximately two-fifths of them. Certain categorized material was placed on a master chart that eventually contained about five thousand entries.

We wish to make it clear that our findings primarily apply to the families we studied. Nevertheless, the fact that these families include at least one psychotic member does not necessarily preclude cautious generalizations to other families in the same ethnic group comparable in social background. We do not know what causes psychosis and in the families studied there are other siblings who

did not become psychotic. Perhaps the families in our study are different in some respect from corresponding ethnic families without mentally ill members. Nevertheless, as a study in the relationship between family social structure and mental stress, we suggest that our findings will be useful as a basis for a better understanding of those fundamental values that characterize the family social structure of the ethnic groups selected and as a stimulus to a greater awareness of the sociodynamics of mental stress.

Our basic premises are that: (1) family social structure is a product of the values originally held by the parents and subsequently internalized by the children; (2) the stability of the cultural pattern of a family through time is encouraged by the transmission of values from one generation to the next primarily in the medium of the family setting through the performance of roles; (3) the nature of these values is of utmost importance in the determination of what the individual family member perceives to be stressful. Since the totality of values in a given family is, in large measure, what has been transmitted from preceding generations, it is reasonable to assume that they will contain many values that we call ethnic. Accordingly, we would expect that particular modes of stress experienced by children of ethnic families would tend to vary with their ethnic values.

For our purposes, stress is a state of unpleasant emotional tension engendered in an individual when he feels that he is unable to satisfy his needs within his situation of action. If the individual is unable to resolve this problem, his state of tension tends to manifest itself in behavior that reflects anxiety and/or hostility laden with guilt about an immediate or anticipated loss of gratification. To satisfy the demands of both clarity and brevity we will confine ourselves here to a consideration of the experience of stress in the male child.

In the area of intra-familial emotional relations there is an alliance or mutual preference between the mother and son in our Irish families. The mother exhibits a sex-linked preferential solicitude. However, she shows a lack of overt affection, which is coupled with strict discipline and a failure to reward in general for parentally approved behavior. The son experiences stress over this constellation of factors and tends to react to them with excessive dependency feelings on his mother which are punctuated by frequent verbal aggressions. The Irish father remains somewhat detached from his son but maintains a supervisory right that is

all-inclusive. Like the mother, the father frequently belittles his son about his "looks" and behavior to make him feel subordinate, which is very stressful to and resented by the son. However, the Irish son does not develop strong emotional reactions toward his father and is apt to accept his subordination to him with little conflict because the number of situations in which he could experience subordination to him is much less in comparison to those he experiences with his mother.

The mother-son relationship in our Jewish families tends to be highly emotional. The mother is apt to be overprotective and overtly affectionate. She employs the withdrawal of love technique as her primary means of control. This emotional situation engenders in the son a distressful concern over the inconstancy of maternal love. He responds to it with highly ambivalent feelings to his mother, combining an exaggerated dependency and deep-rooted repressed hostility. The Jewish father is not very punishing, but he also yields much of the control over his home life to his wife. The Jewish son is not likely to have strong negative feelings toward his father, but neither is he likely to accept him as a role model.

The Italian son is the recipient of sex-linked preferential treatment from both his parents. There is little concern with affection and practically no overt display of it, but the Italian mother is apt to be oversolicitous, partly due to the superior status of males, and partly due to her concern over her son's physical welfare. The father's rigidity and propensity for physical punishment induces the mother to act as a buffer between father and son. The son reacts to this situation by feeling obligated to carry out maternal commands without hesitation, which tends to increase his emotional dependence on her. While the son enjoys the protection provided by his mother against his father, neither parent shows interest in his personal problems. Moreover, the father's extreme strictness tends to create a fear-ridden respect for him in the son, so that the latter feels he cannot dare reject the father as a role model though he rejects him as a symbol of warmth. It is these aspects of the son's emotional position in the Italian home which prove very stressful to him in the long run because role expectations are not supported by emotional security.

The element of positive affect is important in the Yankee family, but there is a pronounced tendency not to display it overtly. The mother is quite overprotective and restrictive in the care of her

son, who often must compete with his sisters for the affections of his father. The competition for parental affection between siblings of both sexes is both intense and highly stressful for the Yankee boy, especially since he has to reach constantly for indirect signs of love in things that his mother does for him rather than to look for and find evidence of love in a more direct fashion. The Yankee father is not very dominant, nor inclined to make much use of physical punishment. He is likely to be rejected as a role model, but also is not apt to be the object of the intense affect that the son feels toward his mother. The great difficulty in identifying with his father in a specific area of conduct and in having to rely almost exclusively on his mother's emotional guidance appears to be very stressful to the Yankee boy. The Yankee mother uses the withdrawal of love technique of control more importantly than any other, but she differs from the Jewish mother by emphasizing the moral implications of transgression rather than its impact upon her personal attitudes. The vague pervasiveness of the moral implications of all his conduct appears to be highly stressful to the Yankee boy, who responds with a deep emotionality to his mother that contains a high degree of guilt and a strong sense of inadequacy.

In the area of role performance Irish and Italian boys are expected to make financial contributions to the family which enhance their prestige in the family. Although this expectation is very mild for Jewish and Yankee boys, what contributions they do make are viewed as love gifts. When such financial contributions are unsatisfactory, the Irish and Italian boys find the situation very stressful in that their family status is jeopardized. In contrast, the Jewish and Yankee boys are inclined to find their inability to contribute to the family exchequer of relatively minor importance. Being a good Jewish or Yankee son in the sense of earning some money is not a function of family service but rather a function of to what "good" or useful personal ends the money earned is put, such as savings or personal future advancement. If a Yankee or Jewish boy does not live up to these expectations, he is apt to experience as much stress in the area of making money as is the Italian or Irish boy who does not contribute sufficiently to the family exchequer.

Both Jewish and Yankee boys are continuously urged to achieve good school marks, to obtain higher education, and to be upwardly socially mobile. The underlying reason is that the Jewish

boy is essentially oriented by his parents to satisfy the personal ambition needs of his parents, particularly his mother. The Yankee boy is pushed by his parents to live up to similar expectations, which are primarily based on moral justifications and upon standards of family reputation. Both Jewish and Yankee boys experience stress when they are unable to fulfill parental expectations regarding education and mobility. They see themselves as having failed in respect to values which they do not question because such values seem to be in complete accord with the highly esteemed American values of education and success.

The Italian and Irish do not encourage their sons to risk the benefits of a regular income from a steady job for the hazards of a promising but uncertain position. This includes not sacrificing immediate earning capacity by going to school in the interests of future occupational advantages. Far from urging their sons to excel in school, Irish and Italian parents in the families we investigated tended to be satisfied if the boys "got by." These boys perceived the situation as stressful, of course, when they were unable to meet even these moderate requirements. However, in contrast with the Jewish and Yankee boys, they experienced stress when they preferred to get a better education and to seek a career conducive to upward social mobility. For them, to do so meant to reject the values of their parents, whom they saw as obstacles to their desires.

The performance of chores is a source of stress most often with Yankee boys. While Irish and especially Italian boys are expected to do chores, they are usually *ad hoc* and for visibly pragmatic reasons. Moreover, their chore load is very small if compared with that of their sisters. In comparison, Yankee boys are assigned routine chores which apparently are not practically necessary, but rather are justified on a moral basis, that it is "right" to have regular obligations, or it is good character training. Further, the Yankee boy is unable to shift any part of his chore load to his sisters, who are expected to do about as much as he. What chores are expected of the Jewish boy are predicated upon practical or moral reasons, or both, but the whole matter is greatly subordinated to other expectations such as doing homework or practicing music lessons. Thus, the Jewish boy seldom experiences as much stress over this as the Yankee boy.

The ability to maintain adequate social relationships outside the family is of great concern to our Yankee families. Thus Yankee families emphasize neatness, pleasant appearance, social amenity,

and "good" social contacts. In part, this is linked with social mobility, and in part, with family status. Although social competence receives less emphasis in our Jewish families, it is important, and it is primarily functional insofar as it enhances the opportunity for upward social mobility. Considerable stress for both Yankee and Jewish boys arises from the incessant concern of their parents that they behave "properly." By comparison, our Italian and Irish parents pay little attention to their sons' social competence other than they don't get into "trouble." Their sons experience stress only indirectly when they feel that they are inadequately prepared for the social intercourse they deem essential to their own plans. This usually occurs when the level of their personal aspirations is higher than that their parents have for them.

Membership in the ethnic group can be a source of stress. This is most frequent with Jewish boys who see their Jewishness as impeding the fulfilment of social or occupational ambitions. Much depends upon the environmental conditions. Indeed, a Jewish boy can select avenues to success that by-pass his Jewishness. However, since this implies a restriction in his freedom of choice, he often cannot quite shake off a diffuse sense of deprivation about his ethnic membership. In Boston, due to the large Irish population, being Irish is generally not a serious obstacle to an ambitious Irish boy. According to our sample, being an Italian rarely seemed to be stressful by itself as an obstacle to upward social mobility. Rather it appears to be parental values discouraging upward social mobility that produce stress in those of our Italian boys who are ambitious.

The above represents selected abbreviated findings which we use to support our basic contention that there are variations between ethnic groups in the modes of stress experienced by their members and that these differences are related to differences in family social structure as influenced by ethnic values. We believe that the application of these findings can be of service to all persons such as physicians, marriage counselors, nurses, social workers, and social scientists who have professional dealings with individuals from the relevant ethnic groups whose adjustment to their social environment is stressful.

SECTION III

Mental Disorder in the Community

TEN

Current Status of Ecological Research in Mental Disorder *

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OUR MAIN purpose in this paper is to evaluate recent studies and criticisms which have appeared dealing with the ecology of mental disorder. The earlier studies dealing with the spatial distribution of "insanity" had a more limited influence than have the more recent studies possibly because of the then infant character of the developing field of psychiatry. However, almost forty years ago MacDermott¹ raised the interesting question as a result of his study dealing with the distribution of "insanity" in England. He asked, "why it was if there was a specific diathesis governing insanity that there should be such vast differences in its geographical distribution?" Such a question points up the fact that the distribution studies of any earlier day tended to be used and thought of in much the same way as the current studies even though the latter generally have been cloaked with the conceptual framework of human ecology.

However, MacDermott's question is of more than passing interest

* Read before the Sociology Section of the Michigan Academy of Arts and Sciences, April 13, 1946. Reprinted from *Social Forces*, 25 (March, 1947), 321-326. Reprinted by permission of the author and the publisher.

¹ W. R. MacDermott, "The Topographical Distribution of Insanity," *British Medical Journal*, London (1908).

for it serves to indicate that the problems raised by the more recent studies are often more numerous than those which they answer. By this remark, I do not mean to throw the baby out with the bath but I intend rather to point up two items: (1) that these ecological studies have definite limitations in enabling us to get closer to the specific etiological factors involved in mental disorders, and (2) that these studies have a significance over and beyond that of bringing us closer to these causative factors.

Thus, specifically in this paper, we wish to do the following: (1) to point to the solid findings and the emerging problems as a result of these studies; (2) to evaluate the criticisms which have been made concerning them; and (3) to give some estimate of the significance of this research both in throwing light on the etiology of mental disorder and in contributing to our knowledge of the society in which we live.

Almost a decade has passed since Faris and I completed the ecological studies of mental disorder in Chicago and Providence. Since that time several other studies have appeared which have served to check the results obtained for Chicago and Providence. Here, I refer to the studies of Green,² Queen,³ Schroeder,⁴ Mowrer,⁵ Tietze,⁶ and Hadley.⁷

Since the major findings of our ecological studies in Chicago are generally known, it seems pointless to repeat them here. My chief concern will be rather to examine the other studies which have appeared to find out the extent to which they test the findings for Chicago. The one point on which all of the ecological studies of mental disorder so far are in agreement is the fact that all types of mental disorder show a wide range of rates in their distribution and that the high rates are invariably concentrated in areas at the center of the city with the rates declining in magni-

² H. W. Green, *Persons Admitted to the Cleveland State Hospital, 1928-37* (Cleveland Health Council, 1939).

³ S. A. Queen, "The Ecological Studies of Mental Disorder," *American Sociological Review*, V (April, 1940), 201-209.

⁴ C. W. Schroeder, "Mental Disorders in Cities," *American Journal of Sociology*, XLVII (July, 1942), 40-47.

⁵ Ernest Mowrer, *Disorganization—Personal and Social* (New York: J. B. Lippincott Co., 1942), chapters 15 and 16.

⁶ C. Tietze, P. Lemkau, and Marcia Cooper, "Schizophrenia, Manic Depressive Psychosis and Social-Economic Status," *American Journal of Sociology*, XLVIII (Sept. 1941), 167-175.

⁷ E. E. Hadley and others, "Military Psychiatry—An Ecological Note," *Psychiatry*, VII (Nov. 1944), 379-407.

tude toward the periphery. Thus, Schroeder concludes in his summary of the evidence that "insanity areas" have been shown to exist. To date ecological studies in nine cities support this finding.

However, when one turns to the distributions of the different types of psychoses, one finds it necessary to be more tentative with respect to agreement of the different studies. In this connection the major finding of the Chicago study was that the schizophrenic cases showed a high degree of concentration at the center of the city while the manic-depressive cases showed a distribution which we described as random in character. The distribution evidence from the five midwestern cities reported on by Schroeder tended to support this finding but not conclusively. For example, Dee reports for St. Louis that "absolutely no correlation exists" between schizophrenic and manic-depressive distributions while Ruess from Milwaukee points out that the manic-depressive distribution, although more random than the schizophrenic, nevertheless shows a concentration of cases in the downtown and river-valley sections. In contrast, Mowrer found that the manic-depressive distribution in Chicago while not "random" has little in common with any of the other patterns. "It seems to be," Mowrer writes, "essentially the concentric-circle pattern with a break in the upper four-fifths of the range." In addition, Mowrer did not find for Chicago as we did the tendency for the manic-depressive cases to come from areas with a fairly high socio-economic level. The lack of conclusive support for this finding may be, as Schroeder points out, the small number of cases available for study in some of these cities—although this could hardly account for the difference which Mowrer reports for Chicago.

With respect to the distributions of the so-called organic psychoses and the toxic psychoses, the agreement in findings is still more tentative. Mowrer's findings for Chicago, in general, support ours. However, with respect to the distribution of senile psychoses, there seems to be little agreement with our finding that these psychoses are highly associated with areas of poverty. Dee reports a similar lack of agreement for the St. Louis data and states that "the high rates as well as the low rates are scattered widely throughout the city."

Again, with respect to our finding that the schizophrenic rates are disproportionately high for persons living in areas not primarily populated by members of their own groups, the only support comes

from the St. Louis data. None of the studies in the other cities has attempted to substantiate this finding.

In our Chicago study the large number of cases available made it possible to compare the rate distributions of the subtypes of schizophrenia. No other study has attempted this and so the marked differences which we found in the distribution of the paranoid and catatonic types of schizophrenia can hardly be accepted conclusively but must await the results of further study. The relatively high correlations obtained for the catatonic and paranoid rates with the percentage of foreign-born and the percentage of hotel and lodging house residents respectively are likely to show marked shifts if new samples would be secured. For example, Mowrer's correlations for each year between 1929 and 1935 for divorce and insanity rates ranged from $.09 \pm .11$ in 1929 to a high of $.78 \pm .05$ in 1935 and these figures give some indication of the manner in which correlations of various indexes with insanity rates may tend to fluctuate. Queen has commented both on the necessity to obtain more refined indexes for measuring specific community conditions as well as the necessity for investigators to agree on the same index in order that the different studies may be more comparable.

Thus, the findings from our original study which have been substantiated by other investigations appear to be the following:

1. That all types of mental disorder show a pattern of distribution within the city where the high rates are highly concentrated in and around the central business district with the rates declining in every direction toward the periphery.
2. That the schizophrenic rates in different cities show a pattern of distribution which is very similar to that of all types of mental disorder.
3. That the schizophrenic rates form an expected typical pattern with the concentration of the high rates in areas of low economic status while the manic-depressive rates show a much wider scatter within the city and show a lack of conformity to the concentric-circle pattern.
4. That persons residing in areas not primarily populated by persons of their own ethnic or racial groups show much higher rates than those of the numerically dominant group.
5. Mowrer's Chicago study has substantiated our finding with respect to the pattern of rates formed by the toxic psychoses and general paralysis.

These, then, seem to be the major findings which have been substantiated by the work done in other cities and by the repeat Chicago study of Mowrer's. Let us now turn to a consideration of the various criticisms which have followed closely in the wake of these studies.

I recall that when our first maps showing the distribution of cases of mental disorder from Elgin State Hospital were prepared, one of the first reactions of the psychiatrists was that the distributions merely represented a selection of cases by public hospitals from the impoverished communities in the city. The persons from the wealthier communities naturally went to the private hospitals. To answer this charge we laboriously set about to collect cases from the private sanitariums in the Chicago area although from the statistics available, the result was really never in doubt. The addition of these cases (17.5 per cent of the total) did not change at all the pattern of the rates as evidenced by a correlation figure of $.99 \pm .001$ between the state hospital rates and the state and private hospital combined rates. Thus, including all cases possible there still remained the demonstrated differences in the distribution of rates; namely, in terms of chances, a person living near the center of the city is about 15 times more likely to be committed to a mental hospital than a person living on the outskirts.

A second reaction of the psychiatrists to our maps was to advance the "drifting" hypothesis. This view emphasizes that the concentration of cases at the center of the city is caused by the fact that the emotionally and mentally unstable fail in their economic life and thus drift to the depressed areas from which they are committed. While this may be a tenable hypothesis, it is extremely difficult to prove or disprove. The factors which possibly are important in evaluating this hypothesis are (1) age at commitment, (2) with whom living, (3) economic history, (4) extent of mobility, and (5) symptomatic character of the disorder. Moreover, these factors would have to be examined with respect to their role in each of the psychoses. While this has not been done in any systematic fashion, certain observations can be made. In the first place the facts concerning age, economic history, and habits of life of alcoholics and persons infected with syphilis point to the conclusion that the patterns of the rates of the alcoholic psychoses and general paralysis have a plausible explanation in the "drift" hypothesis.

However, it is in a consideration of the validity of this hypothesis

applied to the patterns formed by the rates of the functional psychoses which is of major interest to the sociologist. Certainly, the findings with respect to the distribution of the manic-depressive cases give little foundation to the "drift" theory. In fact, it has been held by some that the nature of the manic reaction is such that persons who eventually develop this psychosis are very likely to work themselves into positions of high social-economic status. It is in the examination of the patterns of rates formed by the schizophrenic psychoses that one confronts squarely the question: Does the character of the cultural life and of the interpersonal relations in the areas at the center of the city acting upon the persons who reside there account for the high rates of schizophrenia or are they to be explained by the fact that incipient schizophrenics tend to drift into these areas? It seems to me that to go all out for this latter theory as some psychiatrists have tended to do ignores both a wealth of data which has been collected relative to the growth and expansion of American cities and much of the significant extrant knowledge relative to the organization of our economic life. This theory thus in operation would be analogous to an earlier biological explanation for city slums: namely, that it is not the slums which make slum people but slum people who make the slums.

Let's consider for a moment the foreign-born communities in our cities. Certainly, no one can seriously contend that these communities have been settled by people who have drifted into these areas because of personality instability. Rather have they represented the starting point for various immigrant groups as they have struggled for a better life and a more secure economic niche in our society. In these communities, like others, people are born, grow up, and die, and the sons and daughters of these immigrant groups have in many instances succeeded in getting out of these communities and assuming larger and more significant roles in the life of the community. This is so well-known that it hardly bears repeating. Rather is it that our focus of attention must be on the character of the cultural and interpersonal life which acts on the people who are born into these communities or who have come there from other lands with marked variations in capacity for adjustment.

My studies of the catatonics^a who have been nurtured in this type of community show that they represent sensitive, self-

^a H. Warren Dunham, "The Social Personality of the Catatonic-Schizophrenic," *The American Journal of Sociology*, XLIX (May, 1944), 508-518.

conscious, and timid personalities who find it difficult to come to terms with a type of social life which is terrifically harsh, intensely individualistic, highly competitive, extremely crude, and often violently brutal. Thus, the character of life only intensifies the tensions and anxieties which already have been developed in these personalities. What I have been saying translated into statistical terms merely means that in these communities one's chances of growing up and developing a personality which can adjust in some fashion to our cultural life are less than in those communities at the periphery of the city. To put it very generally one might say that such communities deny for many persons "adequate breathing space" in growing up as is so well depicted in Wright's portrayal of the life of Bigger Thomas in *Native Son*.

This analysis can be made without any smug reference to disorganized areas. It is not that these communities are disorganized, as Whyte⁹ and others have shown, but rather that life is hard, the struggle is sharper, and consequently more personalities have difficulty in coping with it and finding acceptable social economic niches in contrast to the other communities of the city.

I have had to write generally, here, because of our ignorance as to how schizophrenia develops but I am, of course, well aware that speaking of the inability of persons to fit into the life of the community does not explain this disorder. However, we have been concerned with the "drift" theory and I have only been trying to show that such an explanation hardly fits the communities populated by the foreign-born and the first generation born there. The drift hypothesis would perhaps apply most effectively to the hobohemia communities but these represent a very small section of the high rate areas. Even here where queer characters often are found on every hand the selection is by no means exclusively on the basis of mental instability. Rather a host of factors, many economic, operating in the experience of the person, play a role. Rooming-house areas, likewise, are populated by persons who have been motivated by many different situations. Many, as is well known, are persons who use this area as a stopping off place in their struggle for a higher plane of living.

I realize, of course, that these observations do not conclusively dispose of this theory, but I believe that they are relevant to an examination of it. Further, I suspect that when we have a sounder

⁹ William F. Whyte, *Street Corner Society* (Chicago: University of Chicago Press, 1943).

knowledge of both ecological processes and schizophrenic etiology, we shall see the "drift" hypothesis for what it really is, namely, an attempt to annihilate the significance of the ecological findings in much the same fashion that certain persons during the thirties tried to dismiss the depression by explaining the loss of a job on the basis of a person's neurotic makeup or emotional instability. This view, admittedly, seemed a little absurd as the depression deepened, but the fact that it was there is a tribute only to our individualistic thought patterns and not to our capacity for a scientific analysis of our cultural order.

The statistical criticism which Frank A. Ross¹⁰ made of Faris' original rates has been satisfactorily answered both by him and our testing for the significant differences between the rates in the various communities. The conclusion has been that the majority of rates are significant for the different sections of the city and that the significant differences between the rates reaffirm the pattern which had been previously established. While this point is of statistical importance in all ecological studies, nevertheless it is generally observed that differences between high and low rates are too great to have been produced by chance alone.

Another statistical argument which has been launched against these studies is the failure to take account of the factor of mobility in the computation of rates. Here, the point is that in certain communities within the city the population may turn over from two to four times within a year and so it is hardly correct to compute a rate using a population base for one day during the year. One immediate answer to this criticism was to point out that, if the rates in the hobohemia communities were divided by three, these rates would still be the highest in the series. Jaffe and Shanas,¹¹ attempting to avoid the problem presented by the factor of mobility computed the chances by age and sex of a person being committed from a stable area with a median rental under \$50.00 in contrast to an area with a median rental over \$50.00. They standardized the rates for age and sex upon a life table population. They found that in the poorer area a male has 1 chance in 18 of being committed; in the area of higher economic status 1 chance in 21 (for females 1 in 20 and 1 in 22 respectively). These findings do, at least, tend

¹⁰ F. A. Ross, "Ecology and the Statistical Method," *American Journal of Sociology*, XXXVIII (January, 1933), 507-522.

¹¹ A. J. Jaffe and E. Shanas, "Economic Differentials in the Probability of Insanity," *American Journal of Sociology*, XLIV (January, 1939), 534-539.

to substantiate partially the pattern found for all types of mental disorder. If one could eliminate the influence of mobility in the extremely high rate areas, it seems that one might reasonably expect that the chance of commitment would be greater than in either of the so-called non-mobile areas.

Indirect support of these ecological studies showing the highest rates to be in the communities having high rates of mobility is provided by the study of Tietze, Lemkau, and Cooper.¹² These investigators have shown rather conclusively that high rates for psychopathic persons are provided by those who move most frequently in contrast to those who reside for a long period in the same house. What is more, these rates are higher for intra-city migrants than migrants from other communities. In other words, while mobility may affect the rate, the mobile persons are being committed at a higher rate than the non-mobile persons. While this argument cannot be given a more conclusive answer until we know more concerning the patterns of mobility within the different areas of the city, it can be indicated that the evidence to date does much to minimize its significance. This would be especially true if one could show that the "movers" move around in the same local communities.

Now, we come to our final questions. What is the significance of these studies? Do they give us any important clues for revealing the etiology of the different types of mental disorder? Whatever significance these studies eventually may prove to have, I would say now that they have a value which reaches beyond the immediate but pressing problems of etiology attached to the various types of mental disorder. It seems to me that these studies taken together with all of the other ecological and demographic studies of community life provide us with a wealth of basic data which are constantly being called for by city and state planning commissions. More specifically, yet, such studies provide basic information for those community-wide programs which attempt to attack a specific problem as has been demonstrated in delinquency and venereal disease.

The eventual expression of community rates within a city in terms of the chances for a person to be committed to a mental hospital should prove valuable not because of any light it throws on the development of the disorder but rather because of the illumi-

¹² C. Tietze, P. Lemkau, and M. Cooper, "Personal Disorder and Spatial Mobility," *American Journal of Sociology*, XLVIII (July, 1942), 29-39.

nation it gives to the operation of certain socio-economic processes within our society.

These studies and others like them would seem also to have a value for the field of human ecology. For certainly, if human ecology is concerned with the processes which are involved in community growth and decay, it must perforce be concerned with those several conditions in the community which foster community organization or point to community decline. Such systematic knowledge should have a predictive value for the ecologist and these studies along with others like them should contribute to such systematic knowledge.

Turning now to a consideration of their value with respect to discovering the etiological factors behind the mental disorders, we find ourselves on rather uncertain ground. To be sure these studies provide support and justification for the necessity of examining the social situation and its role in the development of mental disorder. But this had been suggested without these studies although specific research into this factor had seldom been attempted. Then, again it has been conventional to say that these studies suggest hypotheses concerning the role of certain social factors. Specifically, with respect to these ecological studies, the factors of social isolation, mobility, and cultural conflict have been suggested. But, it can hardly be maintained that these factors have evolved from the distribution studies. Such studies may give support to theories involving these factors but then only by implication. Cultural conflict had already been emphasized by Malzberg¹³ and Braatoy¹⁴ as a result of statistical analyses previous to the publication of these studies. The theory of social isolation, applied to schizophrenia, developed by Faris¹⁵ and presented in our joint work, is certainly congenial to the sociologically minded person but it does not flow from the ecological distributions nor was it developed from ecological correlations. It is as much in the sociological viewpoint, via the accounts of feral men, as is the notion that interaction with other persons is essential for socialization and personality development. Then, there is the factor of mobility supposedly emphasized by

¹³ B. Malzberg, *Social and Biological Aspects of Mental Disease* (Utica, N. Y.: State Hospital Press, 1940).

¹⁴ T. Braatoy, "Is it Probable that the Sociological Situation Is a Factor in Schizophrenia?" *Acta Neurology et Psychiatrie*, XII (1937).

¹⁵ R. E. L. Faris, "Cultural Isolation and the Schizophrenic Personality," *American Journal of Sociology*, XXXIX (September, 1934), 155-169.

some of the correlations, but, as Queen has pointed out, this is difficult to evaluate because different indexes have been used in the various cities to measure it. Then, too, there is the question of deciding whether mobility refers to the community situation or the residential movement of specific persons. However, if one proceeds to analyze the role of this factor further, as Tietze and his co-workers have done, one is still confronted with the crux of the problem: Do insane persons move frequently or do frequently moving persons become insane? Even if one could answer the first question in the affirmative, one would hardly be on the road to solving the nature-nurture riddle as Tietze implied.

The difficulty seems to be that these factors and others like them are not specific enough either quantitatively defined or verbally defined, and consequently statistical manipulations which proceed from them are very crude. Additional work may make them more usable and more specific. However, it seems rather obvious to me with respect to mental disorder that the big task is to find out how these factors and others like them become incorporated into the experience of those persons who break down with schizophrenia in contrast to those in the same community who do not develop schizophrenia. Then, too, the nonspecific character of these factors as applied to mental disorder is further demonstrated by the fact that they are often used to explain other types of deviant behavior. Cultural conflict has been linked with delinquency and crime, and isolation with suicide.

In reviewing our book, Plant's¹⁶ comment "that such a painstaking piece of work could be done on so many people and yet yield so little knowledge about any one of them" has been regarded by some as not quite fair, and perhaps it was not if confined to the ecological studies *per se*. But, if the ecological studies are to be regarded as instruments to uncover etiological factors in mental disorder, then it seems to me that his comment takes on a new significance—a significance which points directly to the limitations of these studies in clarifying the etiological factors behind mental disorders in all their nosological ramifications.

Krout's¹⁷ earlier criticism of my work attempted to come to

¹⁶ James Plant, "Review of Mental Disorders in Urban Areas," *American Journal of Sociology*, XLIV (May, 1939), 100.

¹⁷ Maurice H. Krout, "A Note on Dunham's Contribution to the Ecology of the Functional Psychoses," *American Sociological Review*, III (April, 1938), 209-212.

grips with this problem and to offer a theoretical viewpoint which would give new meaning to the ecological findings. His contention was that in the stage of the fixation we can see the meaning in the differences of the schizophrenic and manic-depressive distributions. The potential schizophrenic is fixated at the oral stage of development by the frustrations experienced by early feeding. The potential manic-depressive becomes fixated at the anal-erotic level of development because of frustrations in later toilet training. The first occurs among families in the culturally impoverished communities; the latter takes place in families on a higher cultural level.

This charting of the birth and early development of the potential schizophrane and manic-depressive with reference to different economic levels via a psychoanalytic frame work is an interesting if not significant effort to account for differences in the distribution of these psychoses. To imply that frustrations at the feeding level lead to the schizophrenic reaction and frustrations of early toilet training may generate a manic-depressive psychosis seems hardly to fit into what is already known about the character of these two psychotic disorders. Then, too, it seems a little absurd to think that these particular frustrations in childhood training are going to be sharply differentiated by economic levels.

Krout has, perhaps, done nothing more than to demonstrate the almost insurmountable difficulty in obtaining an adequate theory to account for the distributions. Krout, along with Queen and others, points to the need for more complete life histories of persons who develop these psychoses in contrast to those who do not in the same community setting. Perhaps, but one can never know this, the ecological studies may have stimulated demands for the above type of study. Be that as it may, the concluding note would appear to be that these studies have provided important and useful information about our community life; they have revealed little that is significant about the etiological factors which lie behind the various types of mental disorder.

ELEVEN

The Paranoid Pseudo-Community*

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AS FAR as its formal organization and *modus operandi* are concerned, the symbolic behavior of adults is to a very large extent socially derived. It is biological activity which in each child originates in a social field as a part of conjoint activity and tends strongly to operate thereafter in line with existing traditional patterns. Whether normal or not, adult symbolic behavior can be graded roughly according to its relative efficacy as interpersonal communication. At one end of such a scale would lie the highly communicative organization in genuine discussions of public matters in conversation or in print and, for more restricted communities, those in technical journals, monographs, and symposiums. Near the other end would be found symbolic behavior that is relatively ineffectual as interpersonal communication, such as that associated with highly individual preferences, with judgments in aesthetic matters by untrained persons, with most emotional subjects having deep personal values, and with many other unshared or rarely shared attitudes and fantasies. Among these last belong the basic biological functions of human organisms (such as the sexual) that have important social consequences but seldom get well organized within a genuinely shared social field.

In the repertory of all normal persons there is this range from private, inner symbolic conduct, in which the organization is such as to be relatively or completely inadequate as communication, to publicly shared social behavior, where, in order to be able to function as communication at all, the organization has to be maintained at a level sufficiently high to operate as a part of mutual activity. In thinking or private discourse the restrictions, distortions, and compromises are determined mainly by the abilities and limitations,

* From *American Journal of Sociology*, 49 (July, 1943), 32-38. Reprinted by permission of the author and the publishers.

the needs and conflicts, of the one person involved. While this may permit much greater latitude to the private thinker, it also requires of him much less completeness, clarity, and definition, for the simple reason that there is no social "other" participating who needs and demands amplification or explanation. The man communing with himself can and does take great liberties with the linguistic tool given him by his social background.

The clearer and more complete organization in publicly shared communication is purchased at the cost of increased rigidity and conformity to the prevailing cultural pattern. Originally, for each person, this sacrifice is imposed by the necessity for sharing effectively some conjoint activity. Once this form of compromise develops, it is maintained by the success with which it functions. If it falls below the level of intelligible communication (as it does practically every day of everyone's life), the demands of the other person or persons bring it up to that minimal level again by requiring the speaker to restate differently, to amplify, to give examples or demonstrations in verbal or manual terms. Under certain circumstances individuals with socially inadequate development fail progressively to maintain such a level, with the result that they become "socially disarticulated" and very often have to be set aside from the rest of their community to live under artificially simplified conditions.¹ Such are many of the chronically disorganized schizophrenics.

Within a given social group the usual development of language behavior results in a high degree of conformity in speech habits and other modes of communication. On the biological side this occurs because the organs involved are closely similar; and on the cultural side it occurs because language arises in the child under conditions of mutual action with persons who are already linguistically organized, and it operates from then on for the most part in situations calling for the social sharing of activity, of preparation for action, or of the results of action.² In other words, communication is the outgrowth of repeated social acts and is itself an organization of well-defined social habits, which are maintained adequately as any other social habits are, through continued operation under conditions of shared activity.

¹ Norman Cameron, *Reasoning, Regression and Communication in Schizophrenics* ("Psychological Monographs," Vol. 1, No. 221 (1938)), pp. 1-34.

² Cameron, "Individual and Social Factors in the Development of Graphic Symbolization," *Journal of Psychology*, V (1938), 165-84.

It is not quite so obvious at first glance that the preservation of social organization in thinking may be similarly dependent upon the setting-up and maintenance of such social habits as are involved in its more formal aspects, its sequences, its frames of reference, and its correspondence with nonlanguage behavior. Of course, as long as communication with others is not involved, a much lower level of conformity with community patterns suffices for the intrapersonal needs which it must meet. Nevertheless, the practice of frequently talking with another about things one has been thinking in private performs an important function. It helps to maintain a fairly high degree of correspondence between these symbolic systems—the individual and the shared—as to critiques accepted, methods employed, and conclusions reached. Since most significant action ultimately involves social operations, this correspondence makes it more likely that the action will be socially appropriate and will fall within the limits of what others deem possible. The differences existing in the degree to which different activities have been thus shared help to account for the markedly different degrees of social maturity achieved by a given person in different areas. That this is not merely the result of inhibitory influences but also an outcome of simple neglect in exercising a given function publicly is indicated by the fact that neglected forms of symbolic behavior with no special emotional involvement remain, even in superior adults, at a childish level of performance.³

The more personal and private the thing with which one is preoccupied, the less likely is the pondering over it to follow the more strictly formal patterns which shared activity fosters. It should not be concluded, however, that in imperfectly socialized private matters there are no firmly established habits of thinking at all. On the contrary, individual patterns may be very rigid and difficult to change. It is possible to demonstrate this even in asocial, disorganized schizophrenic patients.⁴ Their thinking and their talking give evidence of habit organization which is consistent and idiomatic and which recurs in recognizable patterns; but through a process of progressive desocialization these patterns have become so highly individualized that, to share in their conversation even partially, one must often master their asocial idiom (*metonymy*) and

³ Cameron, "Functional Immaturity in the Symbolization of Scientifically Trained Adults," *ibid.*, VI (1938), 161-75.

⁴ Cameron, "Schizophrenic Thinking in a Problem-solving Situation," *Journal of Mental Science*, LXXXV (1939), 1012-35.

their formally incomplete logic (*asyndesis*).⁵ Personal language habits in these persons have gradually replaced the more social language habits.

As one might expect from the multiplicity of factors involved in developing language habits, operating either as communication with others or in personal thought, there are wide individual variations in the normal product even within a given cultural group. Just as they do in any other habit system, persons differ in the dexterity, flexibility, variety, and aptness of their language habits. The broad fundamental attitudes developing in infancy, childhood, and adolescence are especially important in determining not only vocabulary, syntax, and style but also such basic, generalized social learning as that which leads to ready interchange of opinion and role with other persons; ease and degree of genuine social communication; habitual ability to modify or even reverse one's stand on occasion; tendencies to enter freely into cooperative activities, to accept the judgments of others as to one's own conduct and achievements, and to be able to behave toward one's own behavior as one can toward the behavior of another.

It is hardly going too far to attribute to the development of these habitual social attitudes, these readinesses-to-react in social relationships, most of the responsibility for success or failure in forming appropriate and valid conclusions regarding one's social environment in late adolescence and in adulthood. Among young children of school age there are already clear differences in these results of social learning. With maturity the differences become more pronounced. Most individuals grow less flexible and less suggestible. They learn to conceal and evade more, and their private life of asocial thought with its satisfactions may get quite isolated. Flexibility, the ability to change one's course, the degrees of concealment practiced, and the extent to which one habitually turns to asocial preoccupations for refuge or pleasure—these definitely help decide what the fundamental social relationships between any given individual and his fellows will be. They may easily determine what perspective he is able to gain and how he regards himself; how adequately he grasps the attitudes, plans, and intentions of others with regard to him; and, therefore how he will react to what goes on around him.

⁵ Cameron, "A Study of Thinking in Senile Deterioration and Schizophrenic Disorganization," *American Journal of Psychology*, LI (1938), 650-65.

The high susceptibility of some individuals to slights—intentional, unintentional, or imagined—grows out of an unworkable attitude they have toward themselves as social objects; either they have no stable and dependable attitude, or it is deprecatory or condemnatory and hostile. This makes them especially vulnerable to delusional development, the rudiments of which can easily be seen even among “sensitive” persons who are never deemed neurotic or psychotic by their associates. There are two other factors that may aggravate such a reaction beyond normal bounds. One is the operation of seriously conflicting reactions which can be neither successfully resolved nor allowed for and ignored, particularly if antisocial trends are involved. Another is the tendency to hang on to a conclusion once formed and to build secretly upon it.

Whether one of these factors or another is predominant, the crucial thing with certain individuals is their habitual inability to share their social attitudes with others, to give their growing suspicions an airing, to set them out before another and so make them objective. It is not enough that they are suspicious; they keep their suspicions to themselves, with only halfhearted, abortive attempts to share them, until they have become so involved with their own hidden conflicts and have accumulated and organized so much supporting anecdotal and incidental evidence that they can at best be understood only by an expert after long and careful analytic study. Even then, the same inflexibility and the onward push of their tensions usually prevent any fundamental change in the system of developed attitudes.

Systematized paranoid or paranoic delusions of discrimination and persecution, develop out of the person's attempts to account for situations and happenings that usually are themselves products of his own asocial behavior, his attitudes, and his fantasies. His socially inadequate interchange of attitudes and interpretations with others not only throws him upon his own limited resources for explanations and hypotheses but allows these also to be elaborated without the checks and modifications that the contrary opinions of others, if entertained seriously, would inevitably induce. Such preoccupation, with its collection and noting of incidents, becomes more and more engrossing; it narrows down the interests and activities of the person and further isolates him from the affairs of others.

As the delusional interpretations grow in extent and intensity, the person may be driven finally to try to share his suspicions with

others; but by this time his own beliefs have become so firmly established as a habitual way of thinking that any sweeping, basic modifications are impossible without changing the whole system and abandoning interpretations that were originally developed under conditions of great emotional stress, which is still present. In addition, his suspicions may have become so systematized and intricate that another person cannot enter into the situation easily. The average layman, even if given the opportunity, is unlikely to go to all the trouble it takes to follow step by step the growth of such a delusional system. He either argues against it, thus compelling the paranoiac in defense to evolve new contrary arguments and consolidate further his position; or he dismisses what he does grasp as being absurd or ridiculous and so may get himself classed as another enemy.

As more and more data accumulate, the individual decides that the whole business must be much more than bad luck or isolated casual slights. He concludes, sometimes very suddenly, that a widespread plot is afoot in which a number of persons are implicated, some recognized and some not. This is a crucial stage in paranoid development. There has been a tendency in the past to look upon it as simply a part of some obscure process, localized by some in a diseased brain and by others in a diseased psyche. Both are static interpretations that ignore what the paranoid person is trying to do and in what way his response organization is defective. The central nervous system of the paranoiac, as far as anyone can determine, is structurally well within normal limits; and a restatement of paranoid conclusions in terms of psychic theories that are themselves fixed, intricate, and inflexible seems to be only an exchange of one problem for another, similar one.

The paranoid person, because of poorly developed role-taking ability, which may have been derived from defective social learning in earlier life, faces his real or fancied slights and discriminations without adequate give-and-take in his communication with others and without competence in the social interpretation of motives and intentions. When he feels himself under scrutiny, he proceeds as anyone else might by checking up and by putting together events that seem to belong together. It is clear that by such a process any person, whether normal or not, will tend automatically to organize his environment; and, the more he organizes his environment through his responses to events, the more in turn his responses get organized in terms of this environment. This whole process in

itself is neither abnormal nor even unusual. All persons do it, and all at some time or other make the mistake of organizing events in ways that fail to correspond with the consensus; but the vast majority of persons will then backtrack and revise their interpretive reactions to agree more or less with those of others. The person whose social habits are inadequately developed may try the same thing; but his means for establishing socially valid criteria and for sharing in the consensus are insufficient when conditions of severe personal stress arise. He lacks the necessary social skills involved, first, in being able to suspend judgment until the attitudes of others can be ascertained and, then, in being able to assume these attitudes of others adequately toward himself when the situation demands it.

Obviously, this relative incompetence is not going to be uniform throughout his behavior repertory. His manners, his courtesy toward others, his deference and flexibility in the give-and-take of impersonal conversation, and even his co-operation in competitive group games or community enterprises may sometimes be very adequate. These are public matters which seldom of themselves threaten the integrity and security of the individual. When they become involved it is usually after the delusional developments have expanded. These in most instances begin with personal matters, things that belong nearer the incommunicable even for normal persons. It is easy to understand the almost universality of sexual involvement in paranoid delusions. It is in this sphere that failure to develop genuine social maturity is most frequently encountered in our culture. Sexual attitudes enter relatively seldom into social communication. The ratio of sexual attitudes functioning in private to those freely and genuinely shared with the community is disproportionately high when compared with most other commonly held attitudes. From this standpoint, the greater prevalence of heterosexual preoccupations among women developing paranoid delusions and of homosexual ones among men⁶ probably reflects basic differences in social attitudes rather than biological differences.

The delusion formation itself may begin with preoccupations stimulated and encouraged by conversations, arguments, or reading; it may be started off by some unfortunate incident which lights up doubts and leads to ruminations. The sensitized person, at first preoccupied with his own conflicting responses and then with the

⁶ A. Noyes, *Modern Clinical Psychiatry* (Philadelphia, 1939), pp. 492-98.

possibility that others share his doubts of the facts about himself, inevitably looks around for evidence. Because of his own attitudes or fears regarding himself and because of his relative incompetence in taking the role of others and thus really sharing their attitudes toward him, he is especially vulnerable. Like a child in a dark forest or an adult who has actually been maligned in public, he is primed for certain kinds of happenings rather than others. He is more ready to react to unfavorable or danger signs. His responses tend, first, to select reactions from his surroundings that fit into such an interpretation and, then, to reshape in retrospect things that seemed innocent enough when they occurred, in such a way that they support the trend of his suspicions. In other words, he has become prejudiced with regard to his social environment.

Unlike the normal child or adult, he is not able to get lasting reassurances from others to counteract his developing fear and distrust. As he begins attributing to others the attitudes which he has toward himself, he unintentionally organizes these others into a functional community, a group unified in their supposed reactions, attitudes, and plans with respect to him. He in this way organizes individuals, some of whom are actual persons and some only inferred or imagined, into a whole which satisfies for the time being his immediate need for explanation but which brings no reassurance with it and usually serves to increase his tensions. The community he forms not only fails to correspond to any organization shared by others but actually contradicts the consensus. More than this, the actions and attitudes ascribed by him to its personnel are not actually performed or maintained by them; they are united in no common undertaking against him. What he takes to be a functional community is only a pseudo-community created by his own unskilled attempts at interpretation, anticipation, and validation of social behavior.

This pseudo-community of attitude and intent which he succeeds in thus setting up organizes his own responses still further in the direction they have been going; and these responses in turn lead to greater and greater systematization of his surroundings. The pseudo-community grows until it seems to constitute so grave a threat to the individual's integrity or to his life that, often after clumsy attempts to get at the root of things directly, he bursts into defensive or vengeful activity. This brings out into the open a whole system of organized responses to a supposed functional community of detractors or persecutors which he has been re-

hearsing in private. The real community, which cannot share in his attitudes and reactions, counters with forcible restraint or retaliation, depending upon whether it recognizes his outburst as illness or as wickedness.

It is an important fact that, for the paranoid person, this reaction of the real community becomes further evidence that he has been completely justified in his suspicions and interpretations right along. He has come out into the open with overt action against his supposed enemies and so managed to bring down real social retaliation upon himself. This new phase has the unfortunate effect of making the paranoid pseudo-community become more objective and real to him; for the reactions of the real community in now uniting against him are precisely those which he has been anticipating on the basis of his delusional beliefs. He is more than likely to include all those who frustrate his attempts at obtaining redress or revenge among his persecutors and their accomplices.

By this time his system of interpretations has become firmly organized. He has developed such marked tensions in response to so many ordinary happenings and has built up such an elaborate structure of defensive attitudes that it is virtually impossible for him to alter his conclusions fundamentally. His chief hope for social rehabilitation lies, on the negative side, in his being protected from too much outside interference on the part of inexperienced persons or persons unacquainted with his illness and in his being prevented from taking finalistic overt action in terms of supposed plots or discriminations. For, while the latter action might relieve his tensions temporarily, it eventually only intensifies them and necessitates further overt action. On the positive side, it is sometimes possible through a slow process of retraining to introduce habits of doubt, of entertaining alternative hypotheses in personal matters, and of suspending judgment and overt action.⁷ Something may be achieved in objectifying personal material at the basis of the pathological sensitiveness through therapeutic discussion and "free association"; but the usually mature paranoid case comes for treatment rather too late in most instances for any sweeping reorganizations. For the therapist the task of picking a way through these explosive areas of sensitiveness is like that of getting through a hostile mine field.

⁷ A. Meyer, "The Treatment of Paranoic and Paranoid States," in W. White and S. E. Jelliffe (eds.), *Modern Treatment of Nervous and Mental Diseases* (Philadelphia, 1913).

The almost lifelong difficulty these persons have had in sharing with others, in exchanging and modifying attitudes of a personal character, in entertaining alternative interpretations through the method of role-taking; their pride and the inflexibility of their systems of defense—these make therapy tedious, painfully difficult, and of very uncertain outcome. Usually the most that can be hoped for is the development of a relationship such that a paranoid person becomes convinced of the therapist's genuine impartiality and complete trustworthiness. He may then be willing to come for help whenever the old pseudo-community shows signs of reappearing or a new one seems to be organizing.⁶ This gives him at least one chance for social sharing with another and for the objectivity this engenders. A paranoiac who can develop even a lasting doubt concerning his false interpretations in areas of special sensitivity is already to that degree partially socialized in those areas. It is understandable that in practice a majority of these persons never succeed in achieving so much.

⁶ O. Diethelm, *Treatment in Psychiatry* (New York, 1936), pp. 234-57.

TWELVE

Social Research in the Mental Hospital*

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IN THE past few years the mental hospital has increasingly come to be used by social scientists as a research site. This growth in interest and research activity might be attributed to the special advantages the mental hospital affords for the study of social interaction, as well as to the kinds of problems that can be investigated therein. In this paper I will indicate some of these advantages and discuss some problems that have been and that might be investigated in the mental hospital.

The segregation of the mentally ill in a separate institution, the limitations placed upon patients, and the institutional controls and organization devised to regulate and carry out hospital functions all combine to create certain research opportunities for the investigator. The first of these is ready accessibility of "captive" research subjects.† Many patients, especially those who reside on a locked ward, live their lives in a limited physical space where they are readily accessible to observation. This means that the number and kinds of activities in which these subjects can engage is severely circumscribed and that the investigator can include in his examination a large part of their social interactions. In effect, many parts of the mental hospital, for example a ward, can be delimited as a small-scale social system in which the current interactions of the patient participants are only minimally modified by activity occurring outside of the system. Thus, there is a considerable restriction on the number of variables entering into their social interaction.

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† We are not concerned here with the ethical issues involved in subjecting a mentally ill person to research against his wishes—although this is an important issue to consider.

In addition, the covert aspects of these subjects' transactions—their feelings and sentiments—are more readily observable and more easily inferred. This is so because the mental hospital tolerates and accepts the direct expression of patients' feelings and attitudes. This means that patients will reveal their feelings in unconventional ways and the investigator will not have to contend with the cultural disguises and defenses people ordinarily maintain to prevent observation of their inner emotional life. This opportunity for observing the feeling-life of the subjects is also increased because of the nature of the patient's mental illness. Many patients have their feelings and attitudes easily evoked and cannot control their expression. They have to express their feelings openly because they have scarcely any defensive armor behind which to hide them. This greater accessibility to the inner feeling-life does not mean that the meanings and motivations related to their covert and overt behavior are more easily understood; they merely lend themselves to observation by an investigator in a way that would not be available if the subjects were being studied in more conventional areas of our society.

There is one final advantage in studying patients in the mental hospital—an investigation of deviant and "desocialized" persons and the kind of interactions they carry on may throw light on our conventional structures and processes.

In addition to studying patients, the investigator might also study the interrelations among personnel and the nature of the social organization created and maintained by the staff. This organization has a direct and important therapeutic impact upon the patient. If a patient gets well in this context, the observer can try to specify those aspects of the social structure and those social processes which contributed to this. If a patient remains ill, the investigator can try to discover those aspects of the social system which contributed to the maintenance of his mental illness. In this way patients can be used as an index of the therapeutic effects of the social structure.

SOCIAL STRUCTURE AND MENTAL HEALTH

Many of the social-research projects in the mental hospital have been interested in evaluating the relation of the social structure to the therapeutic course of patients. These studies have ranged from the delineation of cultural or institutional patterns to the identifica-

tion of minute and detailed social contexts. For example Devereux¹ was concerned with identifying general structural factors in the mental hospital that facilitated the patient's recovery. He found these to be the simplicity of hospital life, the concreteness of the social structure, its high degree of consistency and uniformity, and the relatively slow rate of change. Batenian and Dunham² found, on the other hand, that the functioning of the attendant culture and the difference in value systems of patients and staff had untherapeutic effects on patients. The dynamics of this culture was such that it tried to preserve its inner form and structure, and its aim was to bring about complete control of patients without regard to patient welfare. Other studies³ have pointed to the hierarchical structuring of staff relations and the social distance between various levels of personnel, as well as between patients and staff, as factors that might deter patient improvement. Caudill and his co-workers, especially, emphasized the two separate and distinct cultural milieus maintained by patients and staff in the mental hospital they studied. This sharp dichotomy between the patient world and the staff world resulted in a lack of awareness on the part of the staff of the highly organized culture of the patients and the nature of its functioning. Because of this they found that the patient's therapeutic needs were being inadequately met. Barrabee⁴ studied the effect of a mental-hospital structure on the fulfillment of its functions. He delineated the kinds of problems the social organization of the hospital had to cope with and the strains engendered in the process of integrating structure and function. He found the conflict between the therapeutic needs of the patient and the needs of the social system to be an important strain in the hospital structure, especially in the area of "control" of patients.

¹ Devereux, G., "The Social Structure of the Hospital as a Factor in Total Therapy," *American Journal of Orthopsychiatry*, XIX (1949), 492-500.

² Batenian, J. F., and Dunham, H. W., "The State Mental Hospital as a Specialized Community Experience," *American Journal of Psychiatry*, CV (1948), 445-448.

³ Rowland, H., "Friendship Patterns in the State Mental Hospital," *Psychiatry*, II (1939), 363-373. Caudill, W., Redlich, F. C., Gilmore, H. R., and Brody, E. B., "Social Structure and Interaction Processes on a Psychiatric Ward," *American Journal of Orthopsychiatry*, XXII (1952), 314-334.

⁴ Barrabee, P. S., "The Study of a Mental Hospital: The Effect of its Social Structure on its Functions," Unpub. Ph.D. dissertation, Cambridge: Harvard University, 1951.

Stanton and I⁵ have studied a small mental hospital as an integrated social system in which the various subparts function together more or less adequately to fulfill the various purposes of the hospital. We have operated on the assumption that different forms of social organization and different interactional processes will have varying effects on patient behavior and improvement. We have identified detailed and specific ways in which interactional processes and concrete aspects of the social structure affect patients.

On the institutional level we devoted our attention to the differentiation of roles, the communication and decision-making process, and the influence of stereotypes on the operations of personnel. Where the roles of various categories of personnel were not clearly defined, or were overlapping, it became difficult for them to function effectively in the social system. Role-confusion among staff reflected itself in confusion among patients. There is a need to determine the most appropriate and effective ways of differentiating, defining, and organizing roles in the mental hospital; what alterations in conventional roles need to be brought about; how the prestige attached to various roles can best be distributed; what value systems are associated with various roles and how role-conflict develops; and how various roles can complement and be integrated with each other in order to provide the most effective therapeutic context.

We gathered data on the system and processes of communication of staff members and also between patients and staff. We found that the formal organization of the system of communication and the informal means for transmitting and receiving information play an important role in the patient's therapeutic progress. Defects in communicative organization, breakdowns, blocks, distortions, omissions in the transmission of information, the passing on of inadequate or inaccurate data—all may contribute to misunderstandings between and among hospital participants. These misunderstandings tend to perpetuate the patient's mental illness. In one of our investigations⁶ we found that an interference in communication between two staff members who were in direct contact with the patient, and who were also in covert disagreement over

⁵ Stanton, A. H., and Schwartz, M. S., *The Mental Hospital*. New York: Library of Behavior Sciences, 1954.

⁶ Stanton, A. H., and Schwartz, M. S., "The Management of a Type of Institutional Participation in Mental Illness," *Psychiatry*, XII (1949), 13-26.

the patient's management, was regularly accompanied by pathological excitement on the patient's part. When the interferences and barriers to communication were removed and the staff members discussed their disagreement, the patient's excitement disappeared. Caudill⁷ found that the patient group was lacking in adequate channels of communication to the staff and as a consequence developed their own social structure which was insulated as much as possible from friction with the hospital routine. Much more investigative work needs to be done in studying communicative networks in the mental hospital. We need to know the ways in which communicative channels are either deficient or effective in the transmission of information, with what effects on the functioning of personnel, with what influence on the patient's therapeutic course. These data need to be gathered in sufficient detail so that the consequences of the communicative system for patient welfare can be accurately evaluated.

The structure and process of decision-making, that is, the system and methods of distributing authority and responsibility and the exercise of power in the mental hospital, has an important effect on patients. Where we were able to delineate defective organization of decision-making we also found difficulties in performance of function on the part of personnel. Where there was, in addition, an inadequate method of locating these deficiencies in the power arrangements, problems created by an ineffective arrangement for the making of decisions tended to perpetuate themselves. Research needs to be done to acquire detailed information on the participation in the decision-making process of various categories of personnel and the ways in which their participation influences their approaches to and attitudes toward patients. When we have been able to trace with sufficient precision the consequences of different types of power organizations for patient welfare, we can then start to think in terms of what kind of power relations, with what types of participation in the decision-making process, will facilitate patients' mental health. There may be general types of authority arrangements that are universally therapeutic, or there may be specific types of authority structures that are beneficial for only certain kinds of patients.

In one study⁸ we pointed out the kinds of stereotypes that are

⁷ Caudill, *et al.*, *op. cit.*

⁸ Stanton, A. H., and Schwartz, M. S., "Medical Opinion and the Social Context in the Mental Hospital," *Psychiatry*, XII (1949), 243-49.

used by personnel to justify or rationalize a course of action. The precise ways in which these stereotypes develop, their specific effects on patients, and the ways in which they can be recognized and altered in the direction of more realistic appraisal of a social situation await further intensive investigation.

In trying to identify specific and delimited social contexts that tend to elicit or maintain the patient's mental illness, we found it fruitful to view the patient's mental illness as a way of participating in the social process—a process within which and with which he lives, and to which he contributes in making it what it is. This is in contrast to a view that conceives of the patient's mental illness as an entity he has within himself. In our view the illness is not an individual phenomenon independent of the patient's milieu but a phenomenon of a total situation which is part of and takes into account the current social situation. Thus, the patient's mental illness may be stable because it is part of a stable social equilibrium, and a significant alteration in this equilibrium might also occasion a change in the patient's mode of participation (his illness). With this frame of reference the social scientist can try to identify specific social contexts that maintain the patient's mental illness (his "ill" ways of participating) and those that facilitate his mental health (his "more mature" ways of participating). For example, we investigated the influence of certain social situations and constellations of staff attitudes on the continuation of patients' incontinent behavior.* We found that attitudes such as antipathy, disgust, and devaluation of and discouragement about the patient tended to reinforce the patient's habitual mode of incontinent participation. Similarly, situations of conflict or those in which the patient was isolated, abandoned, or devalued precipitated the overwhelming majority of directly observed incidents of patients' incontinence. These attitudes and social situations constituted part of a stable equilibrium in which incontinence was a regularly recurring aspect. On the other hand, when a different type of social context was structured, the same patients who were incontinent in the old contexts rarely participated with incontinence in the new context. The delineation of the social phase of a segment of the patient's behavior, that is, its function and meaning in the social equilibrium, may continue to be a rewarding area of social research.

* Schwartz, M. S., and Stanton, A. H., "A Social Psychological Study of Incontinence," *Psychiatry*, XIII (1950), 399-416.

With a similar orientation we studied the fulfillment of patients' needs on a mental-hospital ward. Staff reactions to the more withdrawn patients included exasperation and anxiety in contacting them, difficulty in communicating with them, and not taking the patients' requests seriously. These reactions tended to work in the direction of maintaining the patient's withdrawal, to which the staff members responded in kind—by withdrawal. In this way an equilibrium of mutual withdrawal was established. This kind of equilibrium was not established with patients whose modes of participation more closely approximated conventional behavior. Thus, a differential in need fulfillment was maintained in which the needs of the more withdrawn patients were less frequently fulfilled.

Interpersonal processes that are considered to be fundamental for patient improvement can be observed closely in the mental hospital. For example, respect for the patient is considered to be such a basic condition. Answers to questions such as the following can be pursued: What are the conditions under which respect and disrespect develop? What are the components of each of these attitudes and how are they identifiable? What are the various manifestations of these attitudes in the mental hospital? What are the ways in which and the means whereby a staff member changes from an attitude of disrespect to one of respect, and vice versa? In order to answer some of these questions the relations between a staff member and a patient might be followed over a time—especially those relations in which the staff member began with a noticeable disrespectful or respectful attitude. The changes and the bases for these changes in the staff members' attitudes on the respect-disrespect continuum could then be carefully noted.

An investigator who is interested in empathic phenomena can find them in profusion on a mental-hospital ward. Personnel are frequently reporting their own nonverbal empathic responses to patients and patients' nonverbal responses to them, as well as making predictions about patients' behavior that are subsequently found to be accurate. Methods need to be worked out for systematically recording and analyzing these empathic phenomena as they occur within this "natural" setting, and for evaluating the relevance of these phenomena for facilitating the patient's mental health.

There are many possibilities for research on the institution of interventions in those social configurations that are found to be illness-maintaining. How these interventions originate, how they

are designed and planned for, their effects and their evaluation and revision are all important aspects that need to be studied. For example, Tudor¹⁰ demonstrated how one might intervene into the process of mutual withdrawal. She found that the withdrawal had to be brought into the nurse's awareness, and that the meaning of the nature of the nurse's mode of withdrawn participation, its psychological basis, and the nature of the equilibrium she established with the patient also had to be clearly seen and understood. After such awareness had developed through discussion with a consultant outside the situation, the nurse could reverse her withdrawal. The interruption of the nurse's withdrawal then contributed to interrupting the patient's withdrawal. G. T. Will and I also were able to intervene into the process of mutual withdrawal by interrupting a nurse's low morale.¹¹ We found that a nurse's low morale was constituted by a pattern of interpersonal processes, such as feelings of failure, anger and resentment, guilt and blame, and constriction of perspective. Further, this pattern of low morale was found to contribute to an integration of mutual withdrawal, in which the patient's withdrawal is in part a function of the nurse's withdrawal and the nurse's withdrawal is a function of her low morale. An interruption of the nurse's low morale was accomplished by the nurse's discussing and analyzing with a consultant outside the situation the ways in which her low morale was initiated, developed, and maintained, and the nature of its contribution to an integration of mutual withdrawal. The raising of the nurse's morale was followed by a cessation of the integration of mutual withdrawal.

At the institutional level Jones and his co-workers¹² have initiated widespread institutional change, especially in the alteration of the communicative network, in an attempt to study the effects on patient improvement. Hyde, Greenblatt and York and co-workers, in studies supported by Russell Sage Foundation and as yet unpublished, have done experimental work in various mental

¹⁰ Tudor, G. E., "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward," *Psychiatry*, XV (1952), 193-217.

¹¹ Schwartz, M. S., and Will, G. T., "Low Morale and Mutual Withdrawal on a Mental Hospital Ward," *Psychiatry*, XVI (1953), 337-53.

¹² Baker, A. A., Jones, M., Merry, J., and Pomryn, B. A., "A Community Method of Psychotherapy," *British Journal of Medical Psychology*, XXVI, parts 3 and 4 (1953), 222-244. Jones, M., *The Therapeutic Community*. New York: Basic Books, 1953.

hospitals in an attempt to determine the most effective institutional ways of improving ward patient care.

The intervention procedure can be a significant tool in the study of social change. When a particular configuration has been identified as illness-maintaining and an intervention instituted to alter this configuration, the social scientist can study the antecedents and consequences of this intervention with a view toward establishing connections between events. Such questions as the following might be explored: How does a particular social context emerge from another social context that preceded it in time? What are the significant transition points in this sequence of events? What is the relation, and how is it established, of any event sequence or configuration of event sequences to the improvement of the patient? These questions are difficult to answer because of the following methodological problems implicit in them which as yet have not been adequately solved and which could be explored in the mental hospital: (a) the delineation of the boundaries of any event or event sequence; (b) the assessment of the relevance of any event or sequence of events to another event or sequence of events; (c) following the complex relation between one configuration and other configurations; (d) isolating and evaluating accurately the significant transition points that have presumably modified a previous context and are shaping an emergent context; (e) developing precision in tracing connections between events and establishing these interconnections in an unbroken flow.

The study of intervention along the lines indicated could most effectively be conducted by the method of participant observation. This method, too, needs careful appraisal and evaluation to insure the collection of valid data. Some important aspects of this process that require further intensive investigation are: (a) the reciprocal influence of the observer and observed, (b) the covert transactions entering into the process, (c) the definition of the observer's role in its formal and informal aspects, (d) the advantages and disadvantages of active and passive participant observation, and (e) the role of anxiety and bias in distorting the data gathered by this method.¹³

I have tried to indicate above the value of using a sociological frame of reference in studying the mental hospital. With this perspective the mental hospital can be viewed as an on-going

¹³ Schwartz, M. S. and C. G., "Participant Observation as a Method of Social Research" (to be published in the *American Journal of Sociology*).

social system in which institutional structures and processes, as well as substructures and subprocesses, are patterned in definable ways. These patterns must be seen in both their formal and informal aspects. Viewed over time, the structure as a whole and specific processes that are part of it produce varying therapeutic effects. The task of an investigator might be to identify and delineate the larger institutional patterns, as well as the more specific social contexts, to see the various processes in their interrelations, and to evaluate and test the relation of these varied social contexts to improvement in the patient's mental health. In developing and testing hypotheses on the relation between mental-hospital structure and mental health it would be important to make comparative studies of large and small mental hospitals. Significant differences in size of hospital, staff-patient ratios, and complexity of organization may reveal different therapeutic or untherapeutic contexts in these different types of institutions; at the same time some common factors may be found that are generally therapeutic, regardless of the size of the hospital.

Studying the relation between the social structure and mental health in the mental hospital, with the patient as the focus, has the advantages of the extreme case: Any alterations that occur in the patient's mental health may be more readily observable and stand out more sharply, especially when the patient makes dramatic changes. However, the study of the relation between social structure and mental health has important implications beyond the mental hospital. It seems reasonable to assume that many of the institutional structures, social contexts, and interpersonal processes that facilitate the recovery of a mentally ill patient will also contribute to the development of mental health in the child while he is being socialized. Specific hypotheses need to be formulated on the basis of findings in the mental hospital and then further tested for their applicability to the process of socialization.

THE STUDY OF GROUP LIFE

There are some problems that have been of continuing sociological interest that can be studied in the mental hospital and that need not be considered in terms of their therapeutic implications. The staff carries on a highly organized form of group life in the mental hospital. Alongside of this, there are some types of patients who live together but are lacking organization among themselves and remain on the level of an aggregate. In between these two

extremes there are, of course, various degrees of cohesiveness in patient groupings.¹⁴ These gradations in the cohesiveness, complex organization, and persistence of various groups in the mental hospital afford the social scientist the opportunity for close comparison. Seeing these groups side by side, as well as in interaction with each other, may enable us to develop knowledge about the bases and factors that account for the differences in group functioning and for the differences in group organization of mentally ill persons.

Patients who maintain only a very tenuous form of group life may provide a critical area for study of the evaluation, persistence, and dissolution of groups in a "natural" setting. In these groups the fluctuations in anxiety of the participants seem to play an important role. Studies need to be formulated to examine the effects of anxiety in such groups. What is the point beyond which anxiety makes group life impossible? Where the group persists in tenuous form, what are the various forms and orientations it takes with increasing or decreasing anxiety? Asking these questions about the relation between anxiety and group life brings us into the problem of the relation between the individual and the group. In these tenuous groups we might be able to trace the effects produced by anxiety in the individual members, who in turn direct or fashion the nature of the group activity under the pressure of their anxiety. Conversely, data can be gathered on the ways in which the group helps allay or minimize the individual's anxiety so that the group cohesiveness is maintained.

COLLECTIVE BEHAVIOR

The susceptibility of patients to anxiety contributes to a type of collective phenomenon we have called collective disturbance, which is readily available for investigation in the mental hospital.¹⁵ We found¹⁶ that collective disturbances of patients on a ward that were intense and persistent over a time were a function of

¹⁴ Schwartz, M. S., "Social Interaction on a Disturbed Ward of a Mental Hospital," Unpub. Ph.D. dissertation, Chicago: University of Chicago, 1951. Slotkin, J.S., "The Nature and Effects of Social Interaction in Schizophrenia," *Journal of Abnormal and Social Psychology*, XXXVII (1942), 345-68. Rowland, H., *op. cit.*

¹⁵ Rowland, H., "Interaction Processes in the State Mental Hospital," *Psychiatry*, I (1938), 323-27.

¹⁶ Stanton, A. H., and Schwartz, M. S., *The Mental Hospital*. New York: Basic Books, 1954.

general institutional disturbances. We were able to trace the development of institutional disturbance through the various hierarchical levels until it reached the patients. The failure in effective functioning of many staff members formed a pattern of reciprocity in which the disturbance of one contributed to that of another so as to increase and spread the effects of the disturbance. The collective disturbance among patients spread in the context of generalized tension in the institution as a whole. From our study we arrived at the conclusion that the communication of tension between and among patients had to be looked at in its complex interrelatedness to the rest of the institution.

The study of such collective phenomena in the mental hospital may provide more detailed and valid generalizations about the development of generalized tensions and the precise ways in which they are communicated. In addition, through the study of collective disturbance, processes of organization, disorganization, and reorganization and their interrelations can be examined.

Because much of the social research in mental hospitals is of recent origin, a great deal of the work in the field is in progress and as yet unpublished. Caudill and Strainbrook, Dunham and Weinberg, Gillin, Le Bar and co-workers, and others have all done broad studies of the social organization and culture of a mental hospital. Von Mering is now conducting a survey of developments in ward-patient care in various hospitals throughout the country; and Mishler is studying staff motivations and commitment to organizational goals in a mental hospital. The interest in studying the mental hospital and the increase of research activity within its confines seems to hold much promise for developing our understanding of the relation between mental health and social structure as well as contributing to our knowledge of human behavior in general.

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Mental Health Needs in a Rural and Semi-Rural Area of Ohio *

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THE study which provides the basis for this report was located in Miami County, Ohio. It was known locally as "the Health and Human Development Project." † The study is believed to have much more than local significance. While all information here reported was collected in Miami County, that County is considered quite representative of a considerable number of rural and semi-rural areas in western and central Ohio. As a result of this representativeness the picture presented in this report is probably much the same in many other localities. . . .

In 1940 this County had a population of about 52,600. By place of residence that population was distributed as follows:

a. About 25,700 people lived in two small cities—Piqua with a population of about 16,000 and Troy with a population of about 9,700.

b. The only other place with more than 2,500 inhabitants was

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† The study was sponsored centrally by the Division of Mental Hygiene of the Ohio State Department of Public Welfare in cooperation with the Department of Rural Economics and Rural Sociology of the Ohio State University and the Ohio Agricultural Experiment Station. Immediate sponsorship was provided through the Division of Mental Hygiene's Bureau of Prevention and Education of which Edward J. Humphreys, M.D., is Chief, and through the Rural Sociology section of the University and Experiment Station Department.

Local sponsorship in the County where the study was located was provided through the local Public Health Department and through a County Mental Hygiene Association in which Harry Wain, M.D., the public health officer, served as Chairman of the Board.

Tippecanoe City, the population of which was about 2,900 in 1940.

c. About 6,700 residents lived in nine incorporated places, scattered throughout the County. The population of these small places ranged from 212 in the smallest to 1,945 in the largest village.

d. This left about 17,300 people living in unincorporated territory. Of these, 12,700 lived on farms. The remaining 4,600 lived in nonfarm homes in the open country and in small, unincorporated villages.

The population is predominantly American-born white, of native white parentage. In 1930, the Census showed that about 96 percent of the population was American-born white and 88 percent was native white of native parents. In 1940, nearly 97 percent of the residents were native-born white persons. Foreign-born white persons comprised only 1.0 percent of the population, and Negroes comprised only 2.2 percent. Most of the relatively few foreign-born residents were born in Germany, England, Canada and Italy, and now live in the two larger cities of the County. Most of the Negroes also live in these two cities.

The majority of workers employed in this County were engaged either in manufacturing or in agriculture. In 1940, machine manufacturing was the largest of the urban industries, though many small plants turned out a great variety of products. Large numbers of workers were engaged, however, in wholesale and retail trade and in the various service trades.

The methods of investigation were those usually employed by social science researchers. These require, of course, the establishment of favorable social relationships between members of the research staff and the local people who cooperate in carrying on the study. Methods of gathering materials for the study included observing directly and recording the life of the community as one lived in it; observational techniques; compiling of information from agency records; using questionnaires, tests and rating devices; and research interviewing. Where numerical data were obtained they were subjected to the usual, careful statistical analysis. . . .

FINDINGS

The following paragraphs summarize some of the major findings with respect to the prevalence of mental hygiene problems:

a. What did the draft reveal?

Based on the record of one of the two local draft boards which, between them, covered the County, it was estimated that at least 10 percent of the men of military age (18-37 years) had personality disorders serious enough to disqualify them for effective military service. This included those rejected with some personality disorder as the leading cause for disqualification. This group alone made up 6.3 percent of all the men examined and 23.6 percent of all those rejected.

It should be remembered that the Army psychiatrist at the induction station based his judgment very largely on the man's civilian record of adjustment. Most of these men, therefore, were more or less seriously maladjusted in civilian life.

It may be assumed that many of those who were rejected for obvious and disqualifying physical defects at the local board were also notably lacking in mental health, though they had no psychiatric examination. Many others were rejected for a variety of physical difficulties which in all probability were bodily manifestations of personality disorders. Finally, a considerable number of men whose emotional difficulties were not detected by psychiatric examiners, or not considered serious enough to bar them from service, had to be discharged later because of "nervous breakdown."

In addition to rejections for personality disorders, 1 man in each 100 of those examined had to be rejected because of mental and educational deficiency. One in each 200 was epileptic, and was disqualified for that reason.

b. What did the study of school children show?

A rough screening, with tests and ratings, of all third and sixth grade children provided a basis for an evaluation of their mental health. It was found that:

- (1) At least 18 percent of all third graders in all schools in the County were poorly adjusted and in need of some kind of mental health aids. An even higher proportion of the sixth grade children showed evidences of poor mental health. In that grade it was estimated that about 21 percent were poorly adjusted children. On the basis of these percentages it was estimated that more than 1,200 poorly adjusted children are to be found in the first 8 grades of the Miami County Public Schools.

- (2) Mental health problems were much more prevalent among boys than among girls.
- (3) Such problems were especially acute among children who were retarded in their school progress and whose advanced age made them misfits in their class.

c. What was shown by the study of juvenile delinquency?

From 1940 through 1945, a six-year period, 1168 delinquency cases were brought before the County Juvenile Court for official or unofficial action. Juvenile delinquency cases brought to court reached a peak in 1943 when 260 cases were subjected to court action. That was nearly 4.0 percent of all children of juvenile court age. These figures do not reveal the total prevalence of delinquency, since the larger number of offenses involving children are dealt with by schools, by parents, by law enforcement officers and by other authorities.

Juvenile delinquency is considered a mental hygiene problem since many children are offenders because of personality distortions or undergo distortion as a consequence of the treatment their behavior provokes. Misconduct in children is often a way of reacting to inner conflicts and frustrations. These, in turn, may reflect external pressures and deprivations which leave basic emotional and social needs unmet. Delinquent behavior is often a substitute gratification for real but unmet needs of the child.

d. How about adult crime?

From 1940 through 1945 a total of 312 persons were indicted in this County for criminal offenses. This includes only those brought before the County Court of Common Pleas to be judged by a grand jury. A total of 112 were found guilty of the offenses with which they were charged. A larger number were ignored by the grand jury. There were, of course, many others dealt with by lower courts.

e. How about commitments to state institutions?

During the six years, 1940-1945, 207 persons were sent from the County to one or another of the state institutions. Of these, 190 were judged "insane" and sent to a state hospital for the mentally ill. Nine were sent to a state institution for the mentally deficient, and 8 to the institution for epileptics.

f. How about divorce?

A striking fact revealed by this survey was the tremendous in-

crease in divorce during the past six years. In 1940 only 140 divorce suits were filed in the County Court of Common Pleas and only 60 divorces were granted by the Court. In contrast, during the year ending June 30, 1946, a total of 432 suits was filed, and 328 divorces were granted. During the six-year period 1,522 divorce suits were filed, and nearly 1,000 marriages were dissolved by the Court.

This study confirms the conclusion of many other studies which show that personality disorders occur as often among farm people as they do among nonfarm residents, and perhaps more often. Estimates of maladjustment among elementary school children in Miami County showed two interesting things in this regard:

a. At both the third and sixth grade levels the incidence of maladjustment, as estimated on the basis of tests and ratings, was less among farm children than among those from nonfarm homes.

b. But the advantage enjoyed by the farm children was much less among sixth graders than among those in the third grade.

The draft board records showed that the rejection rate generally was higher for farm men than for nonfarm men. It was also found that the incidence of personality disorders was greater among farm workers than among other registrants. This study points to the conclusion that, from the point of view of mental health, farm residence is probably an advantage for younger children, but that the advantage is lost with increasing age. Among men of military age, those in other occupations have the advantage over those concerned with farming. This may be due in part at least to migration of disproportionately large numbers of better adjusted youths away from farms and from farm occupations.

On the basis of the findings outlined above it may be conservatively estimated that from 5,000 to 10,000 people in this one County need professional counseling services. This would include only those men, women, and children whose mental health is so far below par as to interfere seriously with their ability to live happily and usefully. Many of these live miserably, and at a level far below their real capacity for effective and efficient functioning at home, in school, on the job, and in community affairs. Most could profit greatly from mental hygiene counseling services provided by psychiatrists and other professional counselors. . . .

Over a six-year period, 190 psychotics, 9 feeble-minded persons and 8 epileptics were committed to institutions by the Courts of

Miami County. This means that some time in his life one person in every twenty-three in the County may expect to be committed to one of these institutions.

The commitments were about equally divided between the sexes (a few more males than expected) and between the two races according to their ratios in the population (a few more Negroes than expected). There were a few very young, and some very old people, but the bulk of the commitments for both sexes fell somewhere near the height of adult life, in the age-period between 30 and 50. These are mostly married people with families, three persons out of four in the group having been married at some time. As far as education is concerned, many of these people had dropped out of school rather earlier than the average, but of those who had gone on, many had gone further in higher education than the average. They are for the most part an urban group, although there is reason to think that this finding depends upon better methods of discovery in the incorporated place, of better opportunities for concealment on the farm and in the open country. The places of birth of these psychotics do not differ greatly from the places of birth shown in the whole draft board sample, and strongly suggest that this is not a problem of immigration from outside the U.S.A., outside the State or outside the County. There is nothing in the records to suggest that an unusually high proportion of mental maladjustment is characteristic of the families of these psychotics.

Of those committed to hospitals for the insane, about 23.7% recover and are released, and 8.4% are released as "improved." The outcome for 20.0% is still in doubt; 23.7% have shown no change in a six-year period, and are probably in hospitals to stay. Death has decided the outcome for 16.3%, and 6.3% had improved initially, but had deteriorated afterwards and had to be re-committed. . . .

RECOMMENDATIONS

WHO WILL CARRY OUT THE RECOMMENDATIONS GROWING OUT OF THIS STUDY?

The following recommendations are made primarily for the benefit of the people of Miami County and for their leaders and officials. Many local persons and organizations have maintained an

active interest in the study and have given it their loyal support. Many have expressed their hope that the project would not terminate with the survey carried out during 1946. Many have asked when confronted with the preliminary findings and with the problems which these findings indicated, "What should be done?" Others have with great sincerity asked, "What can I do?"

No attempt is made at this point to set forth a full and complete action program to meet all mental health needs in the County. Such a program would probably appear utopian at the present stage of thinking with regard to mental hygiene. The recommendations that follow represent the first few important steps. They would make some highly significant contributions to the health and welfare of the people in Miami County, and would carry the County in the direction of an all-out program for the study, treatment and prevention of mental illness and social maladjustments, and for the promotion of mental health.

While these recommendations are addressed directly to the people of Miami County, they are indirectly addressed to all those people of Ohio and the Nation who live outside the large urban centers. Effective mental health services have so far been limited very largely to the large metropolitan centers, cities with 150,000 or more population. This study shows, and other studies show, that mental hygiene needs are as great or perhaps greater in the counties and small cities as in the large centers of population. If Miami County can take steps to work out an effective program for human conservation and development, it will certainly serve as a most valuable example for other rural and small city areas of Ohio and of other states.

Local persons and groups are becoming better informed as to their mental health needs and opportunities. They are not willing to stand idly by and wait for state, federal and other agencies to come in to try to solve their problems. They stand ready to do whatever needs to be done. Where the services and facilities that are needed are beyond local resources, they stand ready to request aid from their state and federal governments and from other agencies which can provide it.

WHAT KINDS OF ACTION PROGRAMS ARE INDICATED FOR THE IMMEDIATE FUTURE?

Since no accepted pattern of approach to mental and social health problems is available it is believed that Miami County

should consider itself a demonstration area. In this area careful and sound programs for meeting crucial mental hygiene problems should be worked out and put into effect as possible patterns for other rural and semi-rural areas to follow.

It appears that four types of programs are indicated or suggested on the basis of present information. These are:

a. A program of *services* for the study and treatment of personality disorders and maladjustments, and for preventive work.

b. A program of mental hygiene *education* to extend mental hygiene information to the public and to build mental hygiene principles and practices into the daily lives of people in homes, schools, factories, and communities.

c. A program of *organization* to procure legislation. Local groups can join forces with other local groups to obtain state legislation and state aids for areas that have health problems requiring resources beyond the ability of the locality to provide out of its own means.

d. A program of continuing *research* and evaluation.

WHAT KINDS OF TREATMENT AND PREVENTIVE SERVICES ARE NEEDED NOW?

a. *Special services needed to help meet adjustment problems of school children.* It is agreed that better child life programs must be devised if mental ill health is to be remedied in its incipency. School curriculums must be better fitted to the varying needs and abilities of children. Special treatment is needed for mentally deficient and slow learning students. Skilled consultation and guidance services are needed in each school. Teachers need to be trained to deal effectively with the social and emotional development of children as well as with imparting knowledge and developing skills. Family relations and community relations need to be developed in the interest of providing better emotional lives for more children. Community child guidance services are desperately needed to serve all children in need of such services.

b. *Child study and special education services in the schools.* The prevalence of maladjustments among school children presents clear evidence that each school system should ultimately have a department of child study and special education, staffed with highly qualified personnel. In Miami County there are too many relatively small systems to make this immediately feasible. There are

two city school systems—Piqua and Troy; three exempted village systems—Tipp City, Covington, and West Milton; and the County system, a total of 6.

It is recommended that a cooperative arrangement be worked out among these school systems whereby a countywide service of child study and special education could be established to serve all the schools in the entire area of Miami County.

It is further recommended that a beginning be made by employing, as soon as possible, at least one specialist in this field. The services of such a specialist would help to meet some of the most crying needs, and would serve as a demonstration of the value to be had from such services.

(1) *What would be the functions of the child study specialist?*

(a) To assess by testing and other methods, the learning difficulties of children who are problems to their teachers and others and to recommend remedial treatment and grade placement.

(b) To study the causes of personality difficulties and personal and social maladjustments among children, and to plan for proper treatment in cooperation with such other guidance services as may be mobilized.

(c) To plan with the schools for the organization of special groups for remedial work for handicapped children and for enrichment work for talented children.

(d) To organize and supervise special classes for mentally retarded and slow learning children.

(e) To organize in-service training programs for teachers who wish to apply mental hygiene principles in the classroom.

c. *The establishment of a demonstration mental hygiene clinic or guidance center to serve the entire population of Miami County.*

It is further recommended that necessary steps be taken to obtain the services of a fully staffed mental hygiene clinic. This should be a residence clinic if possible but otherwise a traveling clinic, the services of which will be shared with other counties. The exceedingly high rates of mental breakdown, neurotic disability, psychosomatic difficulties, delinquent behavior, maladjustment among school children, divorce and other evidences of personal and social difficulties make such a clinic an imperative need. The effectiveness of the child study specialist in the school, the probation worker in the courts, the general medical practitioner, and others

who find deep-lying emotional problems in their subjects will be greatly enhanced by the services of a mental hygiene clinic.

(1) *What is a guidance center or mental hygiene clinic?*

A guidance center is an agency which provides facilities and services for the study and treatment of persons showing deep-seated behavior or personality disorders. It is generally staffed with psychiatrists, psychologists, and social workers. These staff members are especially trained to understand the social, emotional, and mental problems of children and adults, and to help them overcome their difficulties.

If properly operated, the guidance center will not only be concerned with the treatment of personality disorders but also with their prevention by means of education and other methods of promoting mental health.

The professional staff of the guidance center is usually small. As a result, comparatively few persons can be accepted for direct treatment, though many may be studied. Its effectiveness depends upon the existence of other community resources and the cooperation of other agencies.

(2) *What does it cost to operate a guidance center?*

A minimum staff consists of one psychiatrist, a psychologist and one or two psychiatric social workers. The cost of maintaining the services of the minimum staff would probably be from \$30,000 to \$40,000 annually, provided physical facilities for housing the clinic are available.

(3) *To what agency can a rural and semi-rural area like Miami County look for aid in establishing a clinic?*

Since such a venture in mental hygiene would be in the form of a demonstration to the rest of the State and to the Nation as to how mental health problems can be dealt with in small counties, it would seem quite proper for this local area to request State aid in carrying out the program.

The Division of Mental Hygiene in the Ohio State Department of Public Welfare should, therefore, be called upon for whatever kind of aid is needed by the local sponsoring group. Such aid might be advisory, financial, or both. In case a traveling clinic were found more suitable than a residence center the State might be asked to cooperate by furnishing some of the services required.

(4) *What local agency should sponsor the clinical program?*

In areas where mental hygiene clinics have been established they have been set up under the auspices of school systems, departments of health or welfare, hospitals, juvenile courts, mental hygiene societies, and private agencies and foundations.

It is suggested that in Miami County the County Mental Hygiene Association might sponsor the clinical program jointly with the County Health Department.

d. Need for marriage counseling and family life programs.

There is great need (apart from solution of the economic problems of the family) for expert marriage and counseling services, and for educational preparation of youth for marriage and family living. The rearing of mature well adjusted and properly educated people is the most promising long-time solution of the divorce problem and of other problems arising out of personality distortions.

WHAT IS RECOMMENDED AS A PROGRAM OF MENTAL HYGIENE EDUCATION?

It is recommended that the local Mental Hygiene Association seek funds for the employment of an educational and organizational director for at least a six months' period. The person employed would be charged with the responsibility for:

a. Extending the educational influence of the Association by building up an extensive membership of interested citizens.

b. Extending as widely as possible a program of popular mental hygiene information by means of lectures, lecture series, the organization of study and discussion groups; by means of a one, two, or three day institute on mental hygiene, seminars or short courses, etc. Further educational work could be done through the newspapers and other channels of publicity, which have been most helpful and cooperative during the survey period. Findings and recommendations of this survey should be publicized as widely as possible in the County.

WHAT LEGISLATIVE PROGRAMS ARE SUGGESTED?

It is suggested that steps be taken to build up a large-scale citizens' movement to provide an outlet for the existing desire to "do something" about the findings of the survey. A strong County Mental Hygiene Association would then acquaint itself with

mental hygiene and related legislation, and exert its influence to secure the passage of those bills which it considers to merit passage.

WHAT FURTHER RESEARCH IS NEEDED?

It is recommended that the local sponsoring groups request the State Division of Mental Hygiene and the State University to continue the research project along with whatever other programs are undertaken. Two kinds of research are recommended to follow the survey just completed.

a. A program of continuing study and evaluation of the programs of services and education. This is important, because in such a relatively new and experimental venture in mental health for the smaller County, the entire project is somewhat in the nature of a research experiment.

b. It is further recommended that a program of fundamental research into the social, psychological, and economic factors affecting mental health be sponsored by the local groups concerned with health and welfare problems.

Both of these research programs should be set up on a long-time basis and staffed with competent research personnel, with sound knowledge of social relations, mental hygiene, and research methods and techniques.

FOURTEEN

Schizophrenia among Primitives

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THOSE psychiatrists whose theoretical under-pinnings have been derived principally from the formulations of Freud, Jung and Meyer have for some time viewed schizophrenia as an essentially psychogenic disorder. More recently, sociologists and ethnologists have concerned themselves with the problem which this conception poses for them, implicitly emphasizing as it does the social and cultural determinants of human behavior. Realizing that psychogenesis is to a large extent ultimately sociogenesis,¹ they have attempted to demonstrate by comparative methods the sociological backgrounds of the schizophrenic reaction. Their research falls into two general categories: (1) ecological analyses of area rates for modern American cities;² and (2) studies of the incidence of schizophrenia in various primitive (non-literate) societies. Here we shall be concerned with the latter investigations.³

The idea that the functional pathologies are the peculiar curse

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¹ We do not mean to imply that sociological factors are "first causes," and thereby become involved in the sterile argument over which discipline—psychology, biology, sociology—is "basic." Instead, it is simply maintained that most behavior which psychiatrists and psychologists describe as psychogenic, is on further analysis seen to be influenced by the behavior and expectations of other people.

² S. A. Queen, "The Ecological Study of Mental Disorders," *American Sociological Review*, 5:201-209, 1940. R. E. L. Faris and H. W. Dunham, *Mental Disorders in Urban Areas*, Chicago, 1939.

³ Faris and Devereaux have presented partial summaries of the ethnological material. However, the present study is justified by virtue of the fact that it is more exhaustive, and at the same time represents an attempt to ferret out some of the weaknesses of the researches rather than an effort to confirm any sociological hypothesis. Cf. R. E. L. Faris, "Some Observations on the Incidence of Schizophrenia in Primitive Society," *Journal of Abnormal and Social Psychology*, 29:30-31, 1934; George Devereaux, "A Sociological Theory of Schizophrenia," *The Psychoanalytic Review*, 26:315-342, 1939.

of civilized man, while the primitive enjoys perfect psychic health except for the inevitable organic mental "diseases," is no longer tenable. An extensive literature assembled by field-working specialists provides ample evidence that the simpler peoples are more complex than the travellers and arm-chair experts of another day were wont to believe, and that psychogenic aberrations are by no means absent among them.⁴ Indeed, it seems likely that for some primitive groups the rates are very nearly as high as those for the rural United States in recent years.⁵ It is important to note, however, that symptomatologies differ from one culture to the next, and certain disorders such as "Piblakto Insanity," "Latah," "Amok," and the "Witiko Psychosis," found in one society will be non-existent elsewhere.⁶

For the most part, students of comparative psychopathology in general, as well as of schizophrenia in particular, have sought merely to establish the presence or absence of the relevant phenomena in various societies. Among those who report an absence or paucity of schizophrenia are Faris, who declares he found the disorder to be very rare, and perhaps absent, among the Forest Bantu (Africa).⁷ However, like so many other students of the problem, Faris offers precious little information as to methodology. How long he was in the field, and to what extent he was aware of the difficulties of such research remain unanswered questions.⁸

⁴ Kimball Young presents the most complete summary of the relevant material that has appeared to date. See his *Personality and Problems of Adjustment*, New York, 1940, pp. 721-738.

⁵ Ellen Winston, "The Alleged Lack of Mental Diseases among Primitive Groups," *American Anthropologist*, 36:234-238, 1934.

⁶ J. M. Cooper, "Mental Disease Situations in Certain Cultures," *Journal of Abnormal and Social Psychology*, 29:10-17, 1934; F. H. G. Van Loon, "Protopathic-Instinctive Phenomena in Normal and Pathological Malay Life," *British Journal of Medical Psychology*, 8:264-276, 1928; J. M. Cooper, "The Cree Witiko Psychosis," *Primitive Man*, 6:20-24, 1933; Ruth Landis, "The Personality of the Ojibwa," *Character and Personality*, 6:51-60, 1937.

⁷ Ellsworth Faris, "Culture and Personality among the Forest Bantu," in *The Nature of Human Nature* (by the same author), New York, 1937, pp. 278-288.

⁸ The methodological problems involved in comparative psychopathology, such as the definition of abnormality, have been discussed by A. I. Halliwell, "Culture and Mental Disorder," *Journal of Abnormal and Social Psychology*, 29:1-9, 1934; D. Katz and R. L. Schanck, *Social Psychology*, New York, 1938, pp. 539-544; Ross Stagner, *Psychology of Personality*, New York, 1937, pp. 416-444; and Kimball Young, *op. cit.* The writings of Ruth Benedict and Ralph Linton should also be consulted. See John Gillin, "Personality in

He merely states that he ". . . made inquiries of four large hospitals . . ." where no records of such cases existed and where the staff did not remember any; and in the villages ". . . attempts were made to describe the symptoms to the natives, but no comprehension of such disorders was found."⁹ Lopez reports no schizophrenia in the Brazilian interior, the few psychotics found there being essentially cycloid instead of schizoid.¹⁰ Seligman also reports cycloid disorders for New Guinea, but none which were truly schizoid.¹¹ However, as with Faris, Lopez' and Seligman's observations are open to question because of the all-important methodological information which is not provided.

In disagreement with the aforementioned studies are the reports of Hummer and Laubscher. Hummer believed schizophrenia to be one of the most frequently hospitalized disorders among American Indians. Hebephrenic Indians, he writes, have the same delusions, laughter, silliness, lack of initiative and apathy as do whites. Likewise, catatonic cases show alternating periods of stupor and excitement, stereotypes, mutism, negativism, etc.¹² Hummer's data are virtually worthless, however, because he disregarded acculturation, and its associated psychic conflicts as factors in the psychopathology of one-time non-literates. It is most unlikely that even a majority of Hummer's "insane Indians" were true primitives, especially since his study was restricted to hospitalized cases.

Laubscher's study of the South Eastern Cape Bantu (Africa), the Tembu tribe in particular, deserves more detailed consideration inasmuch as the author evidences greater awareness of the crucial methodological issues, and presents a lengthier report than do the others.¹³ It is Laubscher's conclusion that cultural differences do not affect the structure of the reaction enough to make it something different from that which occurs in European societies, though he is well aware of the fact that ". . . the cultural pattern of the Primitive Societies," *American Sociological Review*, 4:681-702, 1940, for an excellent general bibliography.

⁹ Ellsworth Faris, op. cit., p. 288.

¹⁰ C. Lopez, "Ethnographische Betrachtungen über Schizophrenie," *Zeitschrift für die gesamte Neurologie und Psychiatrie*, 142:706-711, 1932.

¹¹ C. G. Seligman, "Temperament, Conflict and Psychosis in a Stone Age Population," *British Journal of Medical Psychology*, 6:187-202, 1929.

¹² H. R. Hummer, "Insanity among the Indians at the Asylum for Insane Indians, Canton, So. Dak.," in H. M. Hurd (editor), *The Institutional Care of the Insane of the United States and Canada*, Baltimore, 1916, I, p. 391 et passim.

¹³ B. J. F. Laubscher, *Sex, Custom and Psychopathology*, London, 1937.

tern to which the native belongs determines the nature of his mental content." He declares, "I think I have produced evidence in this book which points to the 'soma' as the ground for primary consideration—in other words, the study of the individual's constitution."¹⁴ Moreover, it is his conclusion that schizophrenia occurs more frequently in this society than any other psychopathological condition.¹⁵

Actually, Laubscher has by no means established the primary importance of constitutional factors in schizophrenia, and there are several criticisms which may be made of his work. In the first place, as Devereux has noted, Laubscher's schizophrenic diagnoses are debatable in many instances.¹⁶ In spite of the fact that he says that the period of psychic abnormality (*ukutwasa*) prerequisite to the development of the mediumistic powers of the shaman (*isanuse*) is by no means synonymous with schizophrenia, and in spite of the fact that the shaman status carries a great deal of prestige ". . . resulting in a host of charlatans professing to have supernormal powers,"¹⁷ Laubscher concluded that schizophrenia existed wherever *ukutwasa* was reported by the relatives of those afflicted.¹⁸ Secondly, although he found a greater prevalence of schizophrenia among Negroes, civilized and primitive, his conclusion that this fact¹⁹ indicates an inherited somatic basis is discredited by his fallacious assumption that he has studied a truly non-literate people,²⁰ and by his failure to take account of the adjustment difficulties which beset the Negro in Euro-American societies. Thus, while Laubscher's data reflect the probable importance of sociological elements in the etiology of schizophrenia, in his haste to demonstrate a somatic basis for the disorder, he has made no analysis of them.

¹⁴ *Ibid.*, p. 11.

¹⁵ *Ibid.*, p. 231.

¹⁶ Devereux, *op. cit.*, p. 317.

¹⁷ Laubscher, *op. cit.*, pp. 31-32.

¹⁸ *Ibid.*, p. 229 and Appendix.

¹⁹ For the sake of argument we may accept Laubscher's statement as a fact, even though Faris contends that the Negro rate in comparison with the white rate may be high in some societies and low in others. See R. E. L. Faris, "Some Observations on the Incidence of Schizophrenia in Primitive Society," *op. cit.*

²⁰ Devereux, *op. cit.*, p. 317, states, ". . . the tribes in question are at present in the throes of a rather brusquely imposed acculturation process which . . . may account for the occurrence of schizophrenia in the area." See also R. C. Thurnwald, *Black and White in East Africa*, London, 1935.

Other investigators reporting the presence of schizophrenia have recognized that the societies studied were not truly primitive, but on the contrary were either traditionally literate, or had been exposed to Euro-American culture. The presence of the disorder in India has been comparatively well substantiated. Shaw found a high rate for the Parsis of Bombay, an urban trading people.²¹ Dhunjiboy, confirming Shaw's finding, reports that schizophrenia is second only to manic-depressive insanity in India and is especially prevalent among the more highly westernized Anglo-Indians, Parsis and educated Bengalis.²² In Brazil, while Lopez found no schizophrenia among the true primitives of the interior, he did find the urbanized natives along the coast suffering from the disorder.²³ With respect to Malaya, Kraepelin wrote some years ago, ". . . a visit to the institution in Singapore at once showed me that in the most different constituent parts of the mingling of nations there, among Chinese, Tanils, Malays, there were clinical pictures to record which wholly resemble the forms of dementia præcox known to us."²⁴ In another hospital in Singapore, Kraepelin believed he found that almost eighty per cent of the patients presented pictures ". . . about which it could scarcely be denied that they belonged to dementia præcox."²⁵ Other students of Malayan psychopathology do not explicitly mention schizophrenia, and it is not clear whether they found it or not.²⁶

Mead states that Manus wives (Admiralty Islands, Melanesia) sometimes behave in the introverted, regressive manner which we associate with schizophrenia.²⁷ This behavior, she suggests, occurs in reaction to the wife's semi-reject status in the husband's family and village where she is never considered a full-fledged member. Moving out of the primary groups of her childhood and into a strange environment when she marries, she frequently develops

²¹ W. S. J. Shaw, "Some Observations on the Etiology of Dementia Præcox," *Journal of Mental Science*, 16:505-511, 1930.

²² J. Dhunjiboy, "A Brief Résumé of the Types of Insanity Commonly Met with in India. . . ." *Journal of Mental Science*, 16:254-264, 1930.

²³ C. Lopez, "Ethnographische Betrachtungen über Schizophrenie," *op. cit.*

²⁴ Emil Kraepelin, *Dementia Præcox and Paraphrenia*, Edinburgh, 1919, p. 231 (translated from the eighth German edition).

²⁵ *Loc. cit.*

²⁶ F. H. G. Van Loon, 'Protopathic-Instinctive Phenomena in Normal and Pathological Malay Life,' *op. cit.*; H. C. Clifford, *Studies in Brown Humanity*, London, 1898, pp. 189-195.

²⁷ Margaret Mead, *Growing Up in New Guinea*, New York, 1930, pp. 66-67.

feelings of isolation and difference. Among the six cases of mental disorder which Mead observed in Samoa, there were a thirty-year-old man with systematized delusions of grandeur and persecution that might have been diagnosed as schizophrenic, and a fourteen-year-old boy described by Mead as feeble-minded and (?) schizophrenic.²⁸ No attempt is made to relate these disorders to sociological elements, as in the case of the Manus material. Contrary to what might be expected, however, Mead does say that ". . . Samoan culture, before white influences, was less flexible and dealt less kindly with the individual aberrant. . . . The Samoans have only taken such parts of our culture as made their life more flexible, the concept of the mercy of God without the doctrine of original sin."²⁹

CONCLUSIONS

A survey of the literature reveals that the present state of our knowledge of the schizophrenic reaction in non-literate societies is as inadequate as our knowledge of comparative psychopathology in general. This inadequacy becomes apparent when one considers what should be known about the psychopathologies of a wide range of societies. Ideally, answers to the following questions would seem to be called for in the case of each society investigated. (1) What mental disorders are found, and how do the symptom pictures differ from, or resemble those of Euro-American society? (2) To what extent are psychopathological behaviors defined as such in terms of Euro-American values, to what extent are they defined relative to the values of the culture investigated, and to what extent do they represent deviations from universal social norms (e.g. mutism, extreme negativism, homicidal mania, etc.)?³⁰

²⁸ Margaret Mead, *Coming of Age in Samoa*, New York, 1928, Appendix IV.

²⁹ *Ibid.*, pp. 273, 276-277.

³⁰ In spite of the relativistic principle of abnormality elaborated by Benedict (*Patterns of Culture*, Boston, 1934; "Culture and the Abnormal," *Journal of General Psychology*, 10:59-80, 1934) and others; in support of which it is pointed out that the catatonic, paranoiac and epileptic may enjoy acceptability and perhaps occupy superior statuses in some societies, there is nonetheless a limit beyond which the individual's pathology necessitates his excommunication and isolation regardless of the culture. For example, as Stagner notes, extreme catatonia and the later stages of paresis would deprive the individual of even the barest minimum of human traits, so that it is inconceivable that

(3) Which personality and temperament types enjoy the greater opportunities for expression, for drive and wish fulfillment, and in what social spheres do these opportunities exist? (4) What are the adjustment hazards figuring in the histories of individuals ultimately declared abnormal? How are they related to the social organization on the one hand, and to the biology of the individual on the other; and in what ways do they resemble or differ from the adjustment problems of the mentally ill in various Euro-American groups? (5) To what extent do the psychotic productions—language, thought and other behavior in the psychosis—reflect inter- and intra-institutional conflicts; and to what extent do they reflect conflict between social and individual expectations? (6) In what ways may the incidence of mental disorder in the society in question be said to be associated with the "advance" of material culture and civilization?

The students of schizophrenia among primitives have devoted themselves almost exclusively to the question, Where is schizophrenia found? Seligman and Faris report an absence of the disorder in societies which remain largely isolated from white influences, but one may not attach great importance to their findings inasmuch as the data are limited, and methodological assumptions and research operations are veiled and suspect. Yet, in view of the fact that wherever schizophrenia has been reported the society in question has been in process of acculturation, a sociological hypothesis involving the concepts of culture conflict, marginality and shock appears tenable.³¹ Laubscher, Hummer, Dhunjiboy, Shaw, Kraepelin, Lopez, and Mead found schizophrenia among peoples who, though frequently classed as primitive—even by the investigators in some cases—are actually in the throes of acculturation. However, the rarity or absence of schizophrenia among truly primitive peoples generally has simply not been established, in spite of Devereaux's overoptimistic conclusion that it

he would be a genuine member of any society. (Ross Stagner, *op. cit.*, p. 418.) It is not unlikely that case studies of the mentally ill in our own society would indicate a rather frequent awareness of the limits to which the person may indulge his abnormality without losing the social acceptance he desires, as well as an awareness of the ways in which abnormal expression may be utilized as a means of gaining or holding a desired status.

³¹ Devereaux has presented a well formulated hypothesis which deserves consideration in analyzing a series of detailed schizophrenic histories from various primitive groups. G. Devereaux, "A Sociological Theory of Schizophrenia," *op. cit.*

has.³² Moreover, it would seem that the definitive answers to the research questions previously formulated will come only from a body of facts that is at present almost wholly non-existent. That is to say, any satisfactory understanding of comparative psychopathology, either among primitive or civilized societies, must be predicated (1) on reliable diagnoses (and derived statistics of incidence) made by psychiatrists who are willing to honestly entertain sociological hypotheses; and (2) on the interpretation of detailed life histories by psychiatrically oriented sociologists, or preferably, by psychologists and sociologists in collaboration. Unfortunately, such knowledge remains as conspicuous by its absence today as it was seven years ago when Hallowell called attention to our need of it,³³ and the task of the travelling field-worker is considerably complicated by wars and rumors of wars.

³² *Ibid.*, p. 317.

³³ A. I. Hallowell, "Culture and Mental Disorder," *op. cit.*

FIFTEEN

The Mental Health of the Hutterites

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MENTAL disorders have been less affected by the steady pace of medical progress than most other threats to human health. The prevention or cure of other illnesses, particularly those of a communicable and infectious nature, is reaching the point where some, like smallpox, syphilis, and tetanus, are being eliminated as major health hazards. More people can now live to an age when the risk of mental illness becomes great. Goldhamer and Marshall¹ have shown that approximately one in fifteen persons in New York State in 1940 who lived to be 65 years of age has spent some time in a mental hospital. Landis and Page stated that "one of every ten Americans is likely to suffer a serious mental difficulty which will incapacitate them during some part of their lives."² The Hospital Committee of the Group for Advancement of Psychiatry estimated that there were eight and a half million psychiatric cases in the United States during the early 1940's.³ In 1950 about 55 per cent of the patient days in all hospitals were spent by mental patients.⁴

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¹ Herbert Goldhamer and Andrew W. Marshall, *Psychosis and Civilization*, The Free Press, Glencoe, Ill., 1949, 1953.

² Carney Landis and James D. Page, *Modern Society and Mental Disease*, New York, Farrar and Rinehart, Inc., 1939. P. 25.

³ Group for the Advancement of Psychiatry, 3617 W. 6th St., Topeka, Kan., March, 1949. No. 7.

⁴ Charles Schlaifer, "Statement Before the Bureau of the Budget, U. S.

In modern America, mental disorders rank high among the severely disabling illnesses in terms of cost, number of persons involved, chronicity, and suffering. Can this fact be a consequence of the pace of modern living? Were mental disorders less prevalent among past generations who lived in a simpler rural world? Are there some "ideal" cultures where psychic disturbances are relatively rare? These popular questions imply a common theory about cause—the theory that culture and social relationships are deeply involved in the multidimensional causal pattern.

Not many would quarrel with the general proposition that the social setting in which men live and the things they believe are correlated with many of the symptoms of mental pathology. Even a superficial review of hospital, police, and census reports shows that human groups differ widely in their *observed* rates of mental and personality disorders. There is far less agreement about what these variations mean. The question of why and how mental disorders are related to cultural pressures, therefore, requires intensive investigation. Even a partial answer might lead to insights that could result in improvements of presently inadequate methods of prevention, treatment, and cure.

Much of our present-day knowledge of mental disorders has come from patients observed after they became mentally ill outside the setting in which they fell ill. This study considers an entire social system. The healthy as well as the sick people in the population were observed. Enough was known about the entire group, its culture, its values, its demography, and its history to provide insights into the connection that may exist between culture and mental disorders. The work was done under conditions of control of certain dependent variables to a degree unusual in social research with human beings. Our laboratory was the Hutterite sect of North America. Our immediate objective was to find all cases of mental disorder known to have occurred among living members. Our method was to compare these findings with somewhat comparable information from other groups. We also looked for common clinical trends in Hutterite case histories which could be related to major culture patterns. This approach to the study of diseases, the method of comparing their frequency, their patterns, and their distribution in different populations, is technically referred to as *epidemiological*. It assumes that each group can be viewed as

Govt., May 27, 1952," *Memorandum of the National Mental Health Committee*, New York.

a natural laboratory in which factors of illness and health maintain a balance. If the balance in one group seems to differ significantly from that in another, this difference is a clue that can lead scientists to the detection of factors promoting or inhibiting the disease. Goldberger's dramatic use of epidemiological clues to explain, control, and prevent pellagra is perhaps the most well-known psychiatric example.⁵ There can be no guarantee that the same approach will also be effective with other mental disorders, but there is reason for optimism. Mental disorders are definitely not distributed at random throughout the human race. If more can be learned about the precise nature of these population differences, plausible and experimentally testable hypotheses are likely to emerge which can put scientists on the trail of new knowledge in a field now enveloped in mystery and obscurity.⁶

Culture and social relationships are suspected of playing a role in "triggering off" the onset of organic mental illnesses like many of those associated with old age, but the assumption that sociological factors are causal is most widely held for functional mental disorders. It has been stated in terms analogous to those of individualistic psychiatry by persons who regard some cultures as being either healthy or sick mentally. The mental hygiene expert Lawrence K. Frank,⁷ in his book *Society as the Patient*, refers to the American culture as being "sick, mentally disordered and in need of treatment." Read Bain,⁸ a sociologist, speaks of "Our Schizoid Culture." He regards the irrational and contradictory norms of Americans as "neurotic and psychotic societal behavior." Emile Durkheim's analysis of suicide statistics shows that there is support for a theory that social cohesion can provide psychic support to individuals who undergo severe personal trauma, and that suicide rates are a function of anomie—the absence of such social support.⁹ Robert K. Merton has proposed a more general theo-

⁵ Robert P. Parsons, "Joseph Goldberger and Pellagra," *Great Adventures in Medicine*, edited by Samuel Rapport and Helen Wright, New York, Dial Press, 1952. Pp. 586-605.

⁶ For a recent review and evaluation of this approach see: Ernest M. Gruenberg, "The Epidemiology of Mental Disease," *Scientific American*, Vol. 190, No. 3, March, 1954: 38-42.

⁷ Lawrence K. Frank, *Society as the Patient*, New Brunswick, Rutgers Univ. Press, 1949. P. 1.

⁸ Read Bain, "Our Schizoid Culture," *Sociology and Social Research*, Jan.-Feb. 1935. 19: P. 266.

⁹ Emile Durkheim, *Suicide—A Study in Sociology* (translated from the

retical formulation to explain how the social structure of a group exerts pressure upon individuals to become conformists or innovators if they accept the normative cultural goals, or to show their rejection of these goals through ritualistic, retreatist, or rebellious behavior.¹⁰ These theoretical approaches, which all claim that culture and social relationships are dynamic (or causal) factors in producing socially deviant or mentally disordered individuals, are supported by evidence from a number of scientific disciplines.

Mental disorders are abnormal psychological manifestations of the personality. Personality develops in the child and the adult through interaction with their culture. Studies in the area of culture and personality indicate that normal, as well as criminal, delinquent, and other forms of antisocial behavior, are related to cultural factors.¹¹ Such forms of antisocial behavior have much in common with mental disorders. Socially disorganized acts are usually without organic cause; they are learned responses, and they tend to be very disturbing to both the patient and his environment. If culture is a causal factor in antisocial behavior, the hypothesis of a similar relationship for functional mental disorders is plausible.

Sociologists and biometricians have noted that observed frequencies of mental disorders are significantly correlated with certain social variables, such as age, sex, social class, economic status, occupation, ecological area of residence, marital status, ethnic group membership, and other factors. A correlation of social categories and those of mental disease is no proof of causal interrelation, but it suggests the possibility. The social-psychiatric view of Jurgen Ruesch and Gregory Bateson that "psychopathology is defined in terms of disturbances of communication"¹² provides a plausible theory for explaining correlations of the frequency of mental disorders with sociological factors. Social groups probably differ widely in the readiness and training of members to perceive, evaluate, and transmit ideas. They also vary in the learning and

French by John A. Spaulding & George Simpson), Free Press, Glencoe, Ill., 1951.

¹⁰ Robert K. Merton, *Social Theory and Social Structure*, Free Press, Glencoe, Ill., 1949. See especially Chapter IV, "Social Structure and Anomie."

¹¹ Ralph Linton, *The Cultural Background of Personality*, New York, Appleton Century Co., 1945. S. Stansfeld Sargent and Marion W. Smith, ed., *Culture and Personality*, New York, Viking Fund, 1949.

¹² Jurgen Ruesch and Gregory Bateson, *Communication: The Social Matrix of Psychiatry*, New York, Norton, 1951. P. 79.

socialization processes which are facilitated and which shape the channels of communication in individuals and between them. Groups with a high degree of homogeneity and strong common values facilitate interpersonal communication far more and in a qualitatively different manner than those which lack these qualities.

Mental disorders have been and are being studied carefully by medical men. Often they are searching for genetic, organic, glandular, psychosomatic, or neurological factors that might have causal significance. Some are known to exist. But they are never adequate as a total explanation. No one gets general paresis without having had syphilis, but not all persons with such an organic infection get general paresis. There is evidence of familial tendencies in the transmission of some psychoses, mental defects, and epilepsy. Familial transmission, however, is not necessarily conclusive proof of genetic causality. By a process of elimination, the question arises: "What other factors might be etiologically significant?" The socio-cultural environment is one possible answer.

Anthropologists and some psychiatrists have reported the virtual absence of certain mental disorders in some primitive social systems. Moloney¹³ believed the Okinawans to be relatively immune to psychoses and quoted others who have described the Dyaks of Borneo, the Lepchas in the Himalayan Mountains, and the natives of Truk Island as being relatively mature emotionally. Weinberg¹⁴ points out that Robert Faris, Cooper, Devereaux, and Seligman claim schizophrenia to be rare or nonexistent in homogeneous non-literate societies having minimal contact with Western cultures. Ellsworth Faris thinks this to be true for the Bantu people of the African Congo forest because of their intimate social relationships. Devereaux attributes the relative rarity of observed cases of schizophrenia in such cultures to their consistent value structure and their "one answer" universe. Kardiner reports a virtual nonexistence of depression and suicide among the Alorese. Similar observations were made by Carothers in Kenya, in East Africa. Laubscher found cases of schizophrenia but no manic depressions among the Tembu people. Carothers and Seligman speculated further that schizophrenia tends to become manifest in those primitive populations who are exposed to close culture contacts with Europeans and are,

¹³ James Clark Moloney, *The Battle for Mental Health*, New York, Philosophical Library, 1952. Pp. 36-37.

¹⁴ S. Kirson Weinberg, *Society and Personality Disorders*, New York, Prentice-Hall, 1952. Pp. 228-232; 255-258.

as a result, experiencing drastic social changes. This study of the Hutterites in North America was begun on the basis of their reputation of being virtually free of psychotic breakdowns and anti-social activities, although, unlike the previously mentioned groups, the Hutterites are not technologically primitive.

These social-anthropological observations are of uncertain validity. Most of them are based on studies in which there was somewhat limited culture contact, without sampling controls. The frequency of mental disorders cannot be determined without a population census. This is a technically difficult research problem even in an American setting, where there are some diagnostic facilities and hospital records, and where fewer barriers of language and values confront the anthropologist than in similar work among primitive groups. The evidence from social psychology, sociology, medicine, and anthropology makes plausible the theory that culture and social relationships are major dynamic factors. The relationships, however, need not be direct.

There are several partly noncultural methods of explanation which also need be explored. They are not mutually exclusive, and probably all are pertinent to some degree. For example, the tendency for manifesting some mental disorders may be transmitted genetically.¹⁵ Glass¹⁶ has demonstrated that in man genetic qualities can be reinforced by cultural factors which affect mate selection. They may be intensified through inbreeding or become rare through outbreeding. This process, which is technically referred to as *genetic drift*, is a consequence of stable and long-term cultural trends in the choice of marriage partners. It results in a gradual increase or decrease in the frequency distribution of genetic potentialities present in the original group.

Other cultural factors, like public welfare services, the addition of iodine to table salt, or the absence of safety inspection laws in factories, also may have indirect consequences for mental disorders. Such forces help to protect from or expose to injury, infection, or metabolic diseases which can lead to "purely" organic, glandular, or neurological abnormalities with psychological manifestations.

Sociological factors can also intensify or minimize conflicts re-

¹⁵ Franz J. Kallman, *Heredity in Health and Mental Disorder*, New York, Norton, 1953.

¹⁶ H. Bentley Glass, "The Genetics of the Dunkers," *Scientific American*, Vol. 189, No. 2, August 1953. Pp. 76-81.

lated to psychological drives, which are thought by many to have a bearing on some mental disorders. Two common examples are sex and aggression. These basic drives, with which many mental patients cannot cope appropriately in terms of the expectations of their group, are culturally conditioned. Cultures can and do vary greatly in the degree to which they provide channels for expression of these psychological impulses in socially approved ways.

Variations in frequency of mental disorders in different population samples can also be due to sampling error. Differences as large as or larger than 100 per cent are not necessarily significant if they are based on a rare phenomenon and a relatively small population base. For example, in 1951 we found 53 cases of psychosis among 8,542 persons, or 0.62 per cent, of the Hutterite population. If it could be assumed that this phenomenon is distributed at random throughout any population, the confidence limits at the 1 per cent level would be from 34 to 72 cases. This means that in 99 out of 100 such samples the true parameter or count would range from 34 to 72 cases. At the 5 per cent level the confidence limits would be from 39 to 67. Differences within these limits might be significant, but on a statistical basis alone they would not be. We know that mental diseases are not randomly distributed. Variations due to sampling error alone could well exceed the frequency differences observed in any of the studies made so far. This fact should not discourage research in a field where large samples cannot be observed. It does not preclude the possibility that differences found are significant. Many scientific results began with statistically non-significant findings which proved to be truly significant.

Finally, many of the variations in the frequency of mental disorders are without doubt a spurious consequence of variations in diagnostic standards, treatment facilities, completeness of patient enumeration, and willingness of the people to co-operate in the surveys. For example, Page and Landis¹⁷ report that, although there is no clear evidence that the true prevalence of mental disorders has increased, the resident population of civil mental hospitals in New York State has grown steadily from 1910 through 1940. This fact was made possible by an *increase in the bed capacity* of mental hospitals.

The analyst of epidemiological data on mental disorders is confronted with a multiple correlation problem which in reality is far

¹⁷ Carney Landis and James D. Page, "Trends in Mental Disease," *The Journal of Abnormal and Social Psychology*, 1943. 38: P. 514.

more complex than the interplay of factors that have been sketched briefly in this chapter. It is impossible to isolate any of these factors in an even remotely "pure" state, unaffected by the operations of other factors. Human beings, culture, and social life cannot be broken down into basic elements like a complex organic molecule. The only "laboratory" available for the study of such entities as *culture* and *mental disorders* is a human social system which has many attributes other than the two of primary concern to this investigation. The factors that have been referred to are only some of the variables that could contribute to an understanding of our data. They are logical constructs or analytical models, useful because they can be a basis for making inferences about relationships; they make possible the testing of hypotheses. The tests, however, can be made only under conditions of moderate control of some of the dependent variables.

Despite the difficulties which confront investigators in this, as in all other social science problems, there is reason for optimism. It may be possible to locate psychiatrically significant control points of culture through patient detective work. The discovery of direct or even circumstantial evidence that some mental disorders are significantly related to specific culture patterns may be important not only in itself, as is any advancement in human knowledge; it can lead to new ways of inquiry into the psychiatric problems that remain unanswered.

The selection of sociological variables for special attention does not imply any denial of those fairly well established findings in psychiatry which show that mental disorders often involve psychodynamic, organic, and genetic processes. The writers of this article accept the multidisciplinary point of view that all human behavior is a complex process which can be viewed simultaneously from several levels of abstraction. Our focus is primarily on the cultural and social dimensions, but far less insight would have been gained into the problems of mental disorders if there had been no recognition of the importance of other human behavior variables. The writers could not analyze their data with the view of certain intellectually insulated psychiatric cults that mental disorders, perhaps the most complex of human behaviors, can be explained adequately by references to a few factors or even to one. They could not accept the *a priori* assumption in some psychiatric circles that culture and most social relationships can be dismissed

as almost irrelevant to the diagnosis and treatment of mental disorders.

Whether sociological factors can cause psychoses is not easy to discover, but one way to get at the question is to examine the mental health of a secure, stable society. The Hutterites, an isolated Anabaptist religious sect who inhabit a section of the North American Middle West, provide an ideal social laboratory of this kind. These people live a simple, rural life, have a harmonious social order and provide every member with a high level of economic security from the womb to the tomb. They are a homogeneous group, free from many of the tensions of the American melting-pot culture. And they have long been considered almost immune to mental disorders. In a study during the 1930's Lee Emerson Deets said that psychoses were almost nonexistent among them.¹⁸ The Manitoba Provincial Legislature received in 1947 a report which said that the Hutterites "do not contribute to the overcrowding of mental hospitals, since the mental security derived from their system results in a complete absence of mental illness."

Three years ago a research team consisting of the writers of this article—a sociologist and a psychiatrist—and the Harvard University clinical psychologists Bert Kaplan and Thomas Plaut undertook a more intensive study of the Hutterites' mental health. The Hutterite people co-operated generously. In the interest of science they opened their "family closets" and helped us to obtain a census of every person in their community who was then or had ever been mentally ill.

The Hutterites, whose origin as a sect goes back to 1528, are a closely knit group of German stock who had lived together in neighboring villages in Europe for a long time before they migrated to the U. S. from southern Russia between 1874 and 1877. The immigrants—101 married couples and their children—settled in eastern South Dakota. Their descendants have now spread over a wide area in the Dakotas, Montana, and the prairie provinces of Canada. They live in 98 hamlets, which they call colonies. But they remain a remarkably cohesive group; each grownup is intimately acquainted with hundreds of other members in the settle-

¹⁸ Lee Emerson Deets, *The Hutterites*, Gettysburg, Pa., Times Publishing Company, 1939.

ments. The Hutterites believe it sinful to marry outside the sect, and all of the present descendants (8,542 in 1950) stem from the original 101 couples.¹⁹

Cardinal principles of the Hutterites are pacifism, adult baptism, the communal ownership of all property and simple living. Jewelry, art and overstuffed chairs are regarded as sinful luxuries. Radio sets and the movies are taboo. Children are the only possessions to which there is no limit: the average completed family has more than 10. The Hutterites cling to their own customs and are considered "different" by their neighbors. But they are not primitive in the ethnographic sense. They get a grammar-school education and speak English fluently. They read daily newspapers, have a telephone in most colonies and own trucks. Since their own members are not encouraged to seek formal education beyond the primary grades, there are no doctors or lawyers among them, but they utilize such professional services from outside. Each hamlet engages in a highly mechanized form of agriculture. Their business with the "outside world," as Hutterites are apt to refer to their neighbors, usually exceeds \$100,000 per year per colony.

On the surface it seemed that the Hutterites did indeed enjoy extraordinary freedom from mental illness. We did not find a single Hutterite in a mental hospital. The 55 outside doctors patronized by these people said they showed fewer psychosomatic and nervous symptoms than their neighbors of other faiths. But this appearance of unusual mental health did not stand the test of an intensive screening of the inhabitants, carried out colony by colony. Among the 8,542 Hutterites we discovered a total of 199 (one in 43) who either had active symptoms of a mental disorder or had recovered from such an illness. Of these illnesses 53 were diagnosed as psychoses, all but five of them of a functional (non-organic) character.

In short, the Hutterite culture provides no immunity to mental disorders. The existence of these illnesses in so secure and stable a social order suggests that there may be genetic, organic or constitutional predispositions to psychosis which will cause breakdowns among individuals in any society, no matter how protective and well integrated.

The distribution of symptoms among the Hutterites was quite

¹⁹ For a detailed report on the demography of the Hutterites see: Joseph W. Eaton and Albert J. Mayer, *Man's Capacity To Reproduce*, Glencoe, Illinois, Free Press, 1954.

unusual. There were few cases diagnosed as schizophrenia, although elsewhere this is the most common psychosis. Only nine Hutterites had ever manifested the pattern of delusions, hallucinations and other recognized symptoms of schizophrenia; the group lifetime rate was 2.1 per 1,000 persons aged 15 and over. On the other hand, the proportion of manic-depressive reactions among those with mental disorders was unusual; this disorder accounted for 39 of the 53 psychoses, and the rate was 9.3 per 1,000 aged 15 and over. The name of the disorder is misleading; manic-depressives often are not dangerous to other persons, and none of the Hutterite patients were. Their symptoms were predominantly depressive. There was much evidence of irrational guilt feelings, self-blame, withdrawal from normal social relations and marked slowing of mental and motor activities. Five of the patients had suicidal impulses. Two Hutterites had actually killed themselves.

The fact that in the Hutterite society manic-depression is more common than schizophrenia, reversing the situation in all other populations for whom comparable data have been obtained, suggests that cultural factors do have some influence on the manifestation of psychoses. A Johns Hopkins University team of researchers who recently made an extensive analysis of mental hospital statistics concluded that schizophrenic symptoms are most common among unskilled laborers, farmers, urban residents in rooming-house sections and other persons who are relatively isolated socially, while manic-depressive reactions are more prevalent among professional, socially prominent and religious persons, who have a stronger need to live up to social expectations. Our data fit this theory well. Religion is the focus of the Hutterite way of life. Their whole educational system, beginning with the nursery school, orients the people to look for blame and guilt within themselves rather than in others. Physical aggression is taboo. Like the Catholic orders, Hutterites own everything in the name of their church. They eat in a common dining room, pay medical bills from the communal treasury and work at jobs assigned to them by managers elected by the males of the colony. The group, rather than the individual, comes first.

In projective psychological tests the Hutterites, like other groups, show antisocial and aggressive impulses, but in their daily lives they repress these effectively. Their history showed no case of murder, arson, severe physical assault or sex crime. No individual warranted the diagnosis of psychopath. Divorce, desertion, separa-

tion or chronic marital discord were rare. Only five marriages were known to have gone on the rocks since 1875. Personal violence and childish or amoral forms of behavior among adults were uncommon, even in persons with psychotic episodes. There were no psychoses stemming from drug addiction, alcoholism or syphilis, although these disorders account for approximately 10 per cent of all first admissions to state mental hospitals in the U. S. In general our study tends to confirm the theory of many social scientists and public health officials that a favorable cultural setting can largely prevent these forms of social maladjustment.

All this does not entirely rule out the possibility that genetic factors play some part in the unusual proportions of manic-depression and schizophrenia symptoms among the Hutterites. There is some evidence that these disorders tend to run in families. The Hutterites are biologically inbred. Three surnames—Hofer, Waldner and Wipf—accounted for nearly half of all families in 1950. It is possible that the Hutterite group has a disproportionate number of persons genetically prone to becoming depressed—if there is such a predisposition. A team of Harvard University workers is planning to make a follow-up genetic study of the Hutterites.

The question of the relation of mental disorders to culture is difficult to investigate quantitatively. No country has a really complete record of mental disorders among its population. Censuses of patients in mental hospitals are almost worthless for this purpose; they leave out patients who have recovered and mentally ill persons who have never come to the attention of doctors.

The Hutterite study attempted to track down every case of a mental disorder, past or present, hospitalized or not, in the whole living population. It probably succeeded in finding virtually all the cases of psychoses. Similar studies have been made of nine other communities in various parts of the world, and the results are shown in the Appendix of Tables. They give the comparative rates of psychosis, as standardized by the Hutterite lifetime rate and corrected for variations in age and sex distribution. (The Hutterite population is predominantly youthful—50 per cent under 15 years of age.)

On this basis the Hutterites apparently rank third among the ten populations in the rate of psychosis, being exceeded only by two areas in the north of Norway and Sweden. But there is considerable evidence that the count of mental disorders was less complete in most of the other groups; that is, many cases were

missed because their illness was not a matter of public record. The Hutterite population was screened quite thoroughly. It is probable that the psychosis rate among the Hutterites is actually low compared with that of all but the population of the Island of Formosa. It seems to be only 42 per cent of the rate in New York State, for instance, taking into consideration the estimate of Goldhamer and Marshall²⁰ that even in that state (where mental hospital facilities are among the most extensive) there is at least one undetected severely psychotic person for every two in an institution.

The statistical comparison of mental disorder rates has many limitations, but it does offer several promising leads to the puzzle that the problem of functional psychoses presents to modern science. Among the Hutterites, as in all the other populations, the frequency of psychoses increased rapidly with age. Among those who showed manic-depressive reactions, females predominated. The social-biology of the aging process and of sex probably holds worthwhile clues to some of the problems of cause and treatment.

Neuroses were more common than psychoses among the Hutterites, as elsewhere. Four-fifths of the 69 discovered neurotics were female. Melancholy moods were regarded by teachers as the number one emotional problem of Hutterite school children. Hutterite neurotics showed the same tendency as psychotics to take out mental stress on themselves instead of on others. Self-blame and remorse were common, as were psychosomatic headaches, backaches and hysteric paralysis of a limb. There was little scapegoating or projection of hostile feelings by imputing them to others.

There is no evidence of any unusual concentration of hereditary mental defects in the Hutterite population. A total of 51 persons was diagnosed as mentally deficient, and 20 normal persons had suffered epileptic attacks. These epilepsy and mental deficiency rates are not high in comparison with other groups.

How does the Hutterite culture deal with mental illness? Although it does not prevent mental disorders, it provides a highly therapeutic atmosphere for their treatment. The onset of a symptom serves as a signal to the entire community to demonstrate support and love for the patient. Hutterites do not approve of the removal of any member to a "strange" hospital, except for short periods to try shock treatments. All patients are looked after by the immediate family. They are treated as ill rather than "crazy."

²⁰ Herbert Goldhamer and Andrew W. Marshall, *Psychosis and Civilization*, The Free Press, Glencoe, Ill., 1949, 1953.

They are encouraged to participate in the normal life of their family and community, and most are able to do some useful work. Most of the manic-depressive patients get well, but among neurotic patients recovery is less common. Most of the epileptics were either cured or took drugs which greatly relieved the condition. No permanent stigma is attached to patients after recovery. The traumatic social consequences which a mental disorder usually brings to the patient, his family and sometimes his community are kept to a minimum by the patience and tolerance with which most Hutterites regard these conditions. This finding supports the theory that at least some of the severely antisocial forms of behavior usually displayed by psychotic and disturbed patients are not an inherent attribute. They may be reflections of the impersonal manner of handling patients in most mental hospitals, of their emotional rejection by the family and of their stigmatization in the community.

In the Hutterite social order people are exposed to a large number of common experiences. Their indoctrination begins in infancy and is continued by daily religious instruction and later by daily church-going. Hutterites spend their entire life within a small and stable group. Their homes consist only of bedrooms, all furnished in an almost identical manner. The women take turns cooking and baking for everybody. Everyone wears the same kind of clothes; the women, for example, all let their hair grow without cutting, part it in the middle and cover it with a black kerchief with white polka dots. The Hutterite religion provides definite answers for many of the problems that come up.

Despite this uniformity in the externals of living, Hutterites are not stereotyped personalities. Differences in genetic, organic and psychological factors seem to be sufficiently powerful to produce an infinite variety of behavior, even in a social order as rigid as this one. It appears that the nightmare of uniformity sketched in George Orwell's *1984* is actually unachievable in a living society. At least our study in depth disclosed no simple standardization of personality structure among Hutterites. There seem to be definite limits to the effects of socialization on personality.

There is considerable objective evidence that the great majority of Hutterites have a high level of psychological adjustment. Their misfortunes and accidents are alleviated greatly by the group's system of mutual aid. The sick, the aged, the widows and orphans are well taken care of. In the last three decades only about 100

persons (most of them male) have left the community permanently. During World War II about one-third of the men between the ages of 20 and 40 served in camps for conscientious objectors; more than 98 percent of them ultimately returned to their colonies.

There has not, however, been any rush of applicants from outside to join the Hutterite sect. Mental health involves value judgments and depends on what people want from life. Only 19 adults have joined the sect in America during the last few decades. The austere and puritanical customs of the sect impose restrictions which even the members, who learn to accept them, regard as a "narrow path." Their culture is therapeutic only for conformists. There are occasional rebels; the more able ones find a means of expressing themselves by becoming leaders, the less brilliant have difficulties.

The survival of this 16th-century peasant culture in the heart of the most 20th-century-minded continent is a vivid demonstration of the power of values and beliefs. Although our data on the Hutterites' mental disorders clearly demonstrate the inadequacy of a purely sociological approach to the problem of mental health, they do show that culture has a large influence in shaping personality. Psychiatrists who work exclusively in hospitals or clinics cannot see the whole patient as he functions in his total environment. Our findings lead us to conclude that the social relations of the patient and his culture, including the things in which he believes, deserve more attention from psychiatric researchers and clinicians than is commonly given to them.

TABLE 1. MENTAL ILLNESS AMONG U.S. AND
CANADIAN HUTTERITES LIVING IN
THE SUMMER OF 1951

*The Total Hutterite Population on December 31,
1950 was 8,542*

Staff Diagnosis of Illness	Lifetime Morbidity	Active Case Morbidity		Other Cases	
	Total Number Ever Ill	Ill in Summer 1951	Ill but Improved on Aug. 31, 1951	Re- covered by or be- fore Aug. 31, 1951	Status Un- known
Psychoses					
Schizophrenia	9	7	1	1	0
Manic-depressive Reaction	39	3	5	27	4
Acute and Chronic Brain Disorders	5	4	0	1	0
Total	<u>53</u>	<u>14</u>	<u>6</u>	<u>29</u>	<u>4</u>
Neuroses					
Psychoneurotic Disorders	53	24	15	12	2
Psychophysiological, Au- tonomic and Visceral Disorders	16	7	3	5	1
Total	<u>69</u>	<u>31</u>	<u>18</u>	<u>17</u>	<u>3</u>
Mental Deficiency					
Mild	14	14	0	0	0
Moderate	23	23	0	0	0
Severe	14	14	0	0	0
Total	<u>51</u>	<u>51</u>	<u>0</u>	<u>0</u>	<u>0</u>
Epilepsy	20	12	5	3	0
Personality Disorders	6	6	0	0	0
Total Cases	<u>199</u>	<u>114</u>	<u>29</u>	<u>49</u>	<u>7</u>

TABLE 2. TEN GROUPS INVESTIGATED BY INDEPENDENT STUDIES, INCLUDING THE ONE DESCRIBED HERE, ARE ANALYZED FOR PERCENTAGE OF EACH MAJOR DIAGNOSTIC CATEGORY AMONG THEIR PSYCHOTICS

Study	Number of Cases Diagnosed	Per Cent of Cases Diagnosed			
		Schizophrenia	Manic-depression	All Other Diagnoses	Total
Ethnic Hutterites	53	17	74	9	100
Formosa Area	76	57	17	26	100
North Swedish Area	107	87	2	11	100
Arctic Norwegian Village	38	16	5	79	100
West Swedish Island of Abo	94	43	27	30	100
Bornholm Island	481	31	25	43	100
Williamson County, Tenn.	156	27	26	47	100
Baltimore Eastern Health Dist.	367	43	11	46	100
Thuringian Villages	200	37	10	53	100
Bavarian Villages, Rosenheim Area	21	38	10	52	100

TABLE 3. THE HUTTERITE GROUP COMPARED TO THE OTHER NINE BY THE STANDARD EXPECTANCY METHOD *

Survey	Total Population	Actual Number of Cases Found	Expected Number of Cases by Hutterite Norms	Expectancy Ratio
Arctic Norwegian Village	1,325	38	19	1.97
North Swedish Area	8,651	107	94	1.14
Ethnic Hutterites	8,542	53	53	1.00
Bornholm Island	45,694	481	773	.62
Baltimore Eastern Health Dist.	55,129	507	822	.62
Williamson County, Tenn.	24,804	156	271	.58
West Swedish Island of Abo	8,735	94	186	.51
Bavarian Villages, Rosenheim Area	3,203	21	49	.43
Thuringian Villages	37,546	200	617	.32
Formosa Area	19,913	76	194	.39

* For a discussion of this method see Joseph W. Eaton and Robert J. Weil, *Culture and Mental Disorders*, Glencoe, Illinois, Free Press, 1954, Chapter 4.

SECTION IV

Sociological Approaches to the Study of Specific Disorders

SIXTEEN

A Sociological Analysis of a Schizophrenic Type*

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THE PURPOSE of this inquiry¹ is to analyze a transient schizophrenic type who is characterized by a relatively normal childhood and adolescent adjustment, a conflictful, explosive breakdown and a favorable chance for improvement or recovery.² This type is in definite contrast to the chronic schizophrenic who has withdrawing or perverse tendencies from childhood, a slow, insidious breakdown and an unfavorable chance for improvement or recovery—

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¹ This report, which is a phase of a larger inquiry, has been facilitated by a grant from the Social Science Research Council.

² Many dichotomous terms are used in referring to the distinction between the chronic schizophrenic and the acute schizophreniform, as: endogenous vs. exogenous, constitutional or somatogenic vs. psychogenic, true vs. pseudo, predisposed vs. situational, classical vs. atypical, malignant vs. benign, process vs. episodic. The term "schizophreniform" was first used by Langfeldt, then by Wittman and Steinberg. See G. Langfeldt, *The Schizophreniform States* (Copenhagen, 1938).

at least under present conditions of therapy in state mental hospitals.³

This dynamic and developmental classification of schizophrenics differs in the following ways from the static taxonomy of Kraepelin, whose criteria were based upon symptomatic end-reactions:⁴

First, it relates the subject's present psychotic behavior to his past experiences and enables a continuous sequence to be established. Second, it views the subject as an individual rather than in terms of the prejudgments of a category. Third, many schizophrenics have such mingled symptoms that it is difficult to decide the "pigeon hole" in which they belong. (It is not surprising, for example, that in one state hospital 40 per cent of the schizophrenics were categorized as "undetermined."⁵) Fourth, the symptoms of some schizophrenics can change, especially in the early stages of the disorder.⁶

The chief tie-in between the developmental and the static approaches to classification of schizophrenics resides in the different behavior of certain sub-types. By and large, catatonic, undetermined, and a few "paranoid" types have acute onsets and better chances for recovery than simple, hebephrenic and listless or fixed paranoids.⁷ Langfeldt, Bellak, Wittman and Steinberg, among other investigators, have recognized some shortcomings of a static

³ Rosen has treated 37 "deteriorated" schizophrenics so that they either improved or recovered. Were these patients in state hospitals many would not have improved, and some would very likely have spent the rest of their lives there. See J. N. Rosen, "The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy," *Psychiatric Quarterly*, 21 (1947), 1-37.

⁴ See E. Kraepelin, *Dementia Praecox and Paraphrenia*. Edinburgh: E. and S. Livingston, 1919 tr. R. M. Barclay. (Some dynamic psychiatrists claim that because of the omission of these developmental processes the influence of Kraepelin has retarded rather than helped in the understanding of psychotic disorders.)

⁵ P. M. Wittman and L. Steinberg, "Follow-up of an Objective Evaluation of Prognosis in Dementia Praecox and Manic Depressive Psychoses," *Elgin Papers*, December, 1944, p. 244.

⁶ See N. Cameron, *The Psychology of Behavior Disorders*, New York: Houghton, Mifflin Co., 1947. (Sullivan states: "I hold that there are no types of schizophrenia, but only some rather typical courses of events that are to be observed in schizophrenic states. This view is widely at variance with the Kraepelinian psychiatry and its derivatives." See Harry Stack Sullivan, *Conceptions of Modern Psychiatry*, Washington: William Alanson White Psychiatric Foundation, 1945, p. 74.)

⁷ See, for example, O. Kant, "Clinical Investigation of Simple Schizophrenia," *Psychiatric Quarterly*, 22 (1948), 141-151.

classificatory scheme.⁸ They have also emphasized either differences or exceptions to the chronic schizophrenic type in terms of onset and/or duration. During the past war this acute type was frequently observed among members of the armed forces who had explosive psychotic breakdowns and who recovered spontaneously in a short time.⁹ Some subjects even improved markedly on the way to the hospital.¹⁰ Psychiatrists inferred that this transient psychotic episode might be peculiar to military life.¹¹ Although transient

⁸ G. Langfeldt, *The Schizophreniform States*, Copenhagen, 1938. H. A. Pas-kind and M. Brown, "Psychoses Resembling Schizophrenia," *American Journal of Psychiatry* 96, 1379-1388. S. Bellak, *Dementia Praecox*, New York: Grune & Stratton, 1948. Bellak differentiates 3 developmental types on a continuum: (1) the constitutional schizophrenic, (2) the more benign psychogenic schizophrenic and (3) the schizophrenic with hysterical features. P. M. Wittman, "Diagnostic and Prognostic Significance of the Shut-in Personality Type as a Prodromal Factor in Schizophrenia," *Journal of Clinical Psychology*, IV (April, 1948), 211-214. L. J. Meduna and W. S. McCulloch, "The Modern Concept of Schizophrenia," *The Medical Clinics of North America*, Jan., 1945, pp. 147-164. Meduna and McCulloch distinguish between the schizophrenic type with a clear judgment or "sensorium" and the "oneirophrenic" with a confused or cloudy outlook at the time of onset. O. Kant, "Types and Analyses of Clinical Pictures of Recovered Schizophrenics," *Psychiatric Quarterly*, XIV (Oct., 1940), 676-700.

Cameron has recognized these differences, but has criticized them mainly because of unpredictability in outcome and the lack of agreement concerning deterioration. Some "deteriorated" schizophrenics improve and recover and some seemingly adequate persons become unexpectedly disorganized "with only a few paranoid episodes." See N. Cameron, "The Functional Psychoses," *Personality and the Behavior Disorders*, J. McV. Hunt, ed., New York: Ronald Press Co., 1944, II, 899. If we consider, however, that this disorder is a developmental process, the advent of new experiences by either type may readily influence the disorder after it has occurred. This means that even chronic schizophrenia can be reversible, but this tendency is far less frequent and the reasons not clearly known.

⁹ F. J. Braceland and H. P. Rome, "Problems of Naval Psychiatry," *War Medicine*, VI, 217-220. W. Malamud and I. Malamud, "Socio-psychiatric Investigation of Schizophrenia Occurring in the Armed Forces," *Psychosomatic Medicine*, V, 364-375. E. H. Parsons, "Military Neuropsychiatry in the Present War," *Annals International Medicine*, XVIII, 935-940. W. C. Menninger, *Psychiatry in a Troubled World*, New York: Macmillan Co., 1948, pp. 168-169.

¹⁰ A. M. Duval and J. L. Thompson, "Dementia Praecox in Military Life as Compared with Dementia Praecox in Civil Life," *War Medicine*, Nov., 1941, pp. 854-862.

¹¹ Porter states: "There is a type of acute schizophrenia, which occurs in the military setting and which is peculiar to the military service and to prisons. It is an explosive type of reaction with a tendency to recover quite rapidly. The recovery begins almost as the individual is hospitalized with no special

schizophrenics in state mental hospitals do not recover as rapidly, nor perhaps as completely, as the military psychotic casualties, still the civilian subjects are definite enough for analytic purposes.

In our discussion of these transient schizophrenics we will include these topics: (1) their personality development, (2) their precipitating experiences, onset and the social definitions of their disorder, and (3) the duration of their disorders. We will then (4) present a sociological hypothesis to encompass both the episodic and the chronic schizophrenic breakdowns. Before proceeding to these topics we will describe briefly the subjects selected and the methods used.

Subjects. Fifty-three subjects, 36 male and 17 female, were selected from 325 cases in the files of two state mental hospitals. They were selected because they had seemingly the most favorable backgrounds, as well as acute onsets and good prognoses. The subjects were between 19 and 35 years of age¹² (the mean age was 23 years) and were of average or above average intelligence. These limiting categories were necessary because persons in early adolescence or beyond 35 generally have a lesser chance for recovery.¹³ Thirty-one were catatonics, 20 were undetermined, and 2 were paranoid. Thirty-six subjects were white and 17 were Negro; they were mainly from the upper-lower and lower-middle and middle classes; education ranged from six grades of schooling through college; they were from rural as well as urban backgrounds; thirty-two males were veterans. Two males, who were not veterans, were too young to enlist and two were exempted from military service because of farm work. This diversity of backgrounds was desirable in order to ascertain the extent to which the personality processes in this type of schizophrenia were uniform. Though the subjects comprised slightly more than one out of six patients in the files, the proportion is far less. In fact, one case out of ten would be a conservative estimate.¹⁴ Also, the males were twice as frequent as the females, and the Negro males comprised a high proportion of this sample.

type of therapy having been given." See Col. W. C. Porter, "Psychiatry in the Army," *Psychiatry and War*, F. J. Sladen, ed., Springfield, Ill.: Charles C. Thomas, 1943, p. 245.

¹² One male subject was eighteen.

¹³ See Bellak, *op. cit.*, p. 403.

¹⁴ The hebephrenic and simple types were not included in our search through the files because after examining the first fifty we did not find one that approximated the criteria of a transient schizophrenic.

Method. The approach to this study was molar and dynamic rather than atomized and static.¹⁵ This means that a type-construct was formulated from developmental sequences, and that any single component could not be considered apart from its unified context; for isolated aspects of the subjects' behavior could be interpreted as being similar to chronic types on the one hand, and to normals on the other hand. This type is ideal because it tends to be only approximated in reality and because it forms an antithesis to the extreme chronic type.¹⁶

The records in the files of a state hospital provided the initial information for selecting the subjects.¹⁷ This information was used also as a point of departure for prolonged and successive interviews with the subjects. The important data consisted of the subjects' experiences and their reactions to their experiences. Patently, interviews were conducted with convalescing patients who were able to verbalize their experiences. Agitated, confused or disoriented subjects were interviewed when they had improved. Hence, not all subjects could be interviewed at any given time. Moreover, the interviewing process required that a growing rapport with the subjects be fostered in order to get at the more painful conflicts which the subjects would not divulge during the first few interviews. In many instances emotionally supportive relationships were developed to enable the subjects to face their past shocking experiences; this procedure made the interviews almost quasi-therapeutic.¹⁸ Precautions were necessary, too, so that the subjects would not re-experience intolerable shocks from their past conflicts. Certain motives and relationships of the subjects, which were derived from the interviews, were confirmed by the Thematic

¹⁵ For contrasting studies with the atomized and static approaches, which are primarily concerned with the probability of outcome, see P. M. Wittman, "A Scale for Measuring Prognosis in Schizophrenic Patients," *Elgin State Hospital Papers*, IV, 20-34; also H. W. Dunham and B. N. Meltzer, "Predicting Length of Hospitalization of Mental Patients," *American Journal of Sociology*, 52 (1946), 123-131.

¹⁶ See E. W. Burgess and H. J. Locke, "The Ideal Type in Family Research," in *The Family*, New York: The American Book Co., 1945, pp. 754-755.

¹⁷ Fifty-one cases were selected from the Elgin state hospitals. Two cases were known to the writer and had been in other state hospitals.

¹⁸ These supportive relationships were especially necessary for those experiences concerning the subject's immediate breakdown. In this sense Karpman's contention that the social scientist's relationship to the subject is "cold and impersonal" did not apply in our interviews.

Apperception Test. Other corroborating information was obtained from family members and friends of the subjects.

PERSONAL BACKGROUNDS AND PERSONALITY TYPE

Our aim in describing the personal backgrounds of these transient schizophrenic subjects is to derive the dynamics of a personality type which emerge from familial and other social relationships.

With reference to parental backgrounds, none of the parents were hospitalized, though three parents had psychotic breakdowns. Parental instability was pervasive, especially among the mothers, but usually on a neurotic level.¹⁰ Parental incompatibility was noted by 12 divorces and family crises were evident by the fact that 24 of the families were broken for one reason or another before the subjects were twenty years old.

The typical maternal picture was that of an unstable though domineering, somewhat over-protective figure, who instilled a marked dependency into the children and yet incurred their hostility. In four instances the father had this domineering role, but generally he was a passive or indifferent figure. The mother-substitutes, as a grandmother who reared one and an aunt who reared another of two male subjects, had these same attitudinal constellations. Although these parent-child relationships are often noted in chronic schizophrenics, the reactions of the children differed for varied reasons, not the least of which was their ability to participate in the peer group.

The subjects had a normal childhood as defined by the parents or by the other informants. This normality meant that the children were conformistic and were not queer, unduly seclusive, or destructively unruly. But, from parental statements, positive signs of adjustment were also evident, as, "She was a happy child," or "He was a bright child," or "She was a child that learned easily."

During childhood the subjects were not seclusive or withdrawn. Although some were situationally isolated because of the inaccessibility of other children, they did not lose confidence in their

¹⁰ Darrah, however, found no psychotic parents in his study of a somewhat similar schizophrenic type. See L. Darrah, "Shall We Differentiate Between Schizophrenia and Dementia Praecox?" *Journal of Nervous and Mental Diseases*, 91 (1940), 323-328.

ability to establish relationships with others. Some subjects, however, were prevented from associating with their peers by the mothers. Yet they were usually followers, or on the periphery of the play group. None were leaders in the group. Presumably this type of disorder does not exclude leadership behavior, but it was not apparent in this group. As one typically stated, "I was not forward with my friends, but just followed the crowd."

Their peripheral position in the peer group was consistent with their general relationships which emerged from a lowered self-esteem and emotional dependency. Their intensified desires for reassurance were begun in parent-child relationships and sometimes were reinforced by intensified sibling rivalries.

Because of their need for reassurance, their aggressions, which were originally directed against one of the parents or the siblings, became associated with anxiety and self-condemnation. Usually they inverted their aggressions against themselves. This behavior led to silent rages, to negativism, and to a sustained stubbornness. But their interest in people was not diminished. In fact, one of their chief aims was to be accepted by other persons, outside as well as inside the family. From another vantage point, since the subjects were very sensitive, they could not tolerate personal rejection very easily, and were more readily controlled by their primary relationships.

But, in direct conflict with their deep need for approval, the subjects, especially the males, had intense and over-compensatory aspirations. Some aspired for almost inaccessible goals and others felt it necessary to attain whatever goals were prescribed for them by their parents. With these achievement motives some became exceptionally competent students; others were vocationally adjusted, at least externally; and still others, who did not attain their aspired goals, considered themselves failures. Their inability to assess their own limitations and/or the limitations of given situations in which they participated was one direct contributing factor in their subsequent breakdowns. By their relatively passive attitude outwardly, and by their intense demands upon themselves coupled with an intense sensitivity to rejection, they found themselves in emotionally vulnerable situations. Then their inverted aggression made their self-reproach all the more intense, and their failures all the more magnified. The males felt this most keenly in their vocational and job pursuits, often coupled with failures or frustrations in their courtship and marital relationships. The females were

chiefly affected by their frustrations in courtship and marital relations.

Their intimate social relationships in the heterosexual sphere were often met by profound personal rejection, especially among the females. These experiences sometimes provided the most direct clues to the disorder. In this respect some subjects did not differ much from chronic schizophrenics.

None of the females had what might be called a reciprocal love relationship. They were jilted or involved in loveless marriages or abused and exploited in their relations with men. Some were disinterested in men, and others made compulsive efforts to obtain dates as a defiance of the strict regimen of the parents, particularly the mother. The most conspicuous fact was their inability to cope with the social techniques of male courtship because of their ignorance of female cultural defenses in this regard, because of their inhibited aggressive tendencies, or because of their inability to withstand the termination of the courtship relationship.

The males also were conspicuously ignorant in their relations with the opposite sex. Some only went as far as to desire or love some girl from a distance, or in their fantasy, or sought out very dominant or older girls. Others had relationships with many women, but could not foster socially intimate relationships for a sustained period. Some subjects also had latent homosexual tendencies, as was brought out by the T.A.T. or by their fantasies. Even among those who fostered intimate contacts, in no instance did the courtship or marital relationship become both harmonious and sanctioned by the mother. Either the subject could not establish a mature heterosexual relationship or the mother opposed his relationships. For example:

B. W. had been going with a girl for four years. They had been very much in love, but the girl was Catholic and he was Protestant. She would not consent to marry him unless he took instructions in Catholicism, so the children could be reared as Catholics. He consented and proceeded to take instructions. To accumulate money for his marriage he worked unusually hard, ten or more hours daily. He also hoped for a raise and this expectation stimulated him to work harder; but he did not get this anticipated raise and was keenly disappointed. Meanwhile, his mother opposed his taking instructions and maintained that the patient was being tricked into becoming Catholic. The patient said that he was not tricked, but did so voluntarily. His mother, then, argued with and upbraided the girl, who in anger returned the

engagement ring to him. The patient was so overcome that he went into a deep depression. He claimed that going with the girl was the most important thing in his life, that without her he could not go on living. He became very depressed, had suicidal thoughts, began to lose hold of himself, and then "went to pieces."

Throughout their experiences they seemingly had an intense drive for personal growth. Some even seemed to become compulsively more sociable and/or attempted to break away from familial constraints. Hence the onset often occurred during a period of hastened but frustrating efforts at compulsive socialization or personal emancipation. This is in contrast with the chronic schizophrenic who usually experiences a period of personal decline before the manifest onset. But, they were not prepared to cope with the crises which they experienced, and became more severely disorganized.

Moreover, many seemed to be in the indecisive state resulting from a cultural imbalance. The veterans experienced considerable imbalance after discharge from the armed forces, especially in their career aspirations and in their attitudes toward women. Some Negroes felt this in their encounters with the White world; another group of Negroes, immigrants from the rural South, felt it in adjusting to the urban North. The females found their greatest disjuncture between the family expectations concerning the female role and sex behavior, and their actual experiences with men in the community.

Prior to the schizophrenic onset, seven subjects manifested neurotic and depressive disorders which required hospitalization. The others, too, had neurotic tendencies, but not intense enough to require hospitalization or private treatment. This schizophrenic type may experience neurotic reactions, with high components of anxiety or depression, in which the conflicts are still very active.²⁰ The schizophrenic onset can be considered a penetration of the neurotic defenses and a need for the patient to resort to a more profound level of defensive behavior.²¹ In some cases it was hard to discern whether the subject was neurotic or schizophrenic. This was because the patient seemed to be in the borderland of the two disorders. Because the psychotic defenses were not crys-

²⁰ See W. R. Miller, "Relationship Between Early Schizophrenia and Neuroses," *American Journal of Psychiatry*, 96 (Jan., 1940), 887-896.

²¹ See R. W. White, *The Abnormal Personality*, New York: The Ronald Press Co., 1948, p. 529.

tallized, this acting-out of the excitement sometimes led to such diagnoses as "schizophrenia with hysterical feature," or "neurosis with schizophrenic features," or "schizophrenia with depressive or manic features."

Prior to the onset the subjects' feeling of isolation in the family increased, because they could not communicate their conflicts and because of intra-familial hostility. For example, one subject became highly upset because of being deserted by her husband. She had an affair with a man much older than herself, but dared not tell her mother who was very nervous and who would severely condemn her, while her siblings thought she was "putting on an act" by her agitated condition; and they either reprimanded or ignored her. Other subjects were quite secretive about their personal affairs, although they were sociable in many other ways. At any rate, in no case was there any attempt by the family to reach the subjects in terms of their particular conflicts. But many subjects, as well as their families, did not know that a breakdown was in process until it had occurred. The following summarized case will serve to illustrate this sequence of personal experiences:

The subject, when last seen, was 28 years old and married. She had been committed in the hospital as schizophrenia undetermined, remained four months and then was discharged outright. After her discharge her general personality condition was perhaps better than it was before the schizophrenic onset.

The youngest of three siblings, she was always an obedient and "model" child. Though she claims never to have wanted for affection from her parents, she felt certain subtle attitudes of rejection because the parents had hoped for a boy and were disappointed with a girl. Though the center of attention, and considered the baby of the family, she felt lonely because of the age discrepancy between herself and her sisters. As a child she often played alone but made friendships which were cut short by the family movements. Her predominant feeling, even as a child, was that of being "different" and "inferior" because her playmates dressed better than she did; she felt that she was poorer than other girls, notions which her parents laughingly dispelled. During early adolescence the initial rejection which she formerly felt in a vague way become more manifest. This feeling was aggravated because she could not compete successfully with her older sisters. In addition, her parents set such high standards for the children that she often felt that she was a "failure" in anything she attempted.

Because the father was so intent upon his daughters getting married, she made every effort to know boys. With this outlook she was

seduced when she was 16 by a man 25, who promised to marry her.

At 17 she left home to attend college; had a difficult time in her studies and was unable to foster friendships with other students. After one year she transferred to another college. Apart from her studies her main preoccupation was in getting dates. Since this was during the war years, male students were fewer and dates harder to get. In a trial and error process she finally met, became enamored of and engaged to a soldier. Having been sexually intimate with him, she became struck with periodic guilt, but became very dependent upon him because, as she stated, he proved she "was worthy enough to be loved." She made friends at her dormitory, was pledged to a sorority and became an accepted member of the group. After getting to know them well she quarrelled with these dormitory friends. By siding with one group who promised to get her into a sorority she so antagonized her other friends that they would not speak to her. Very lonely and dejected, she felt that her chief self-support and fulfillment of her father's desire were concentrated in sustaining her engagement and the hope of eventually getting married. When her fiancé broke the engagement because he preferred another girl, she became despondent and confused, had a spree of crying, feared she would never get married, and considered herself a failure. But she had no one to whom to turn for consolation or advice. She dared not tell her parents, whom she felt were nicer to her during her engagement. She could not go to her friends who were not on speaking terms with her. Perplexed, distracted and depressed, she was unable to study, would stare about her until finally a glass caught her eye. She kept thinking of "how easy it would be" to eat some glass and get out of her misery. The next day, while attempting to study, she abruptly got up, broke the glass, ate some splinters, became frightened at what she had done, ran to the psychiatrist who also became upset, but who said she could not stay in school and advised her to become a volunteer patient at a mental hospital.

When she entered the hospital she was uncommunicative, disoriented and intermittently agitated. She received seven shock treatments and improved continually until her release.

ONSET PROCESS AND SOCIAL DEFINITION OF THE DISORDER

The breakdown experiences cover three interrelated phases: (1) the precipitating situations which immediately preceded the onset, (2) the onset process, and (3) the social definition of the disorder.

Although the precipitating situations may seem relatively unim-

pressive to an impersonal observer, these situations are extremely threatening to the subjects. Thus, the precipitating situations at best provide external indexes to the inner attitudes leading to the onset. Generally, these situations encompassed conflicts with some family member, the spouse, a friend of the opposite sex, or associates in industry. Although the subjects were usually affected by a series of precipitating situations, which in combination affected their breakdown, the decisive experience—i.e., “the straw that broke the camel’s back”—pertinent to the onset showed the following differences for males and females: Fifteen male subjects broke down because of difficulties on the job or in school, but only one female broke down because of these experiences; ten males and nine female subjects were affected by quarrels with the opposite sex; seven males and five females were affected by family quarrels; and four male and two female subjects had other miscellaneous experiences before the breakdown. The female subjects seemed to be primarily affected by their relationships with the opposite sex or the family. The male subjects, though frequently upset by these phenomena, also encountered emotional upheavals from frustration in their careers or jobs.

The onset process concerns the personality changes during the breakdown. In contrast to the chronic schizophrenic, who puts up one or a series of feeble fights as he slowly drifts into disorder, the transient schizophrenic puts up a vigorous struggle in the effort to reorient himself and to regain a more acceptable self-evaluation. His onset brings to a head a vigorous effort at conflict resolution, but one in which no solution is immediately forthcoming.²²

This characterization of the onset is crucial in differentiating another pattern of development in which the subject seems to be well adjusted externally, and seemingly has an acute breakdown. Yet, on closer inspection his breakdown has been far more gradual than was first apparent. This type does not fight to regain a higher self-esteem, but rather after an acute reaction seems to be resigned to his disorder. In Kraepelinian language, his disorder combines catatonic and hebephrenic defenses.

The transient schizophrenic does not have this deep and per-

²² See A. T. Boisen, *Exploration of the Inner World*, Chicago: Willet and Clark Co., 1936; also T. M. French and J. Kasanin, “A Psychodynamic Study of the Recovery of Two Schizophrenic Cases,” *Contemporary Psychopathology*, S. S. Tompkins, ed., Cambridge: Harvard University Press, 1947, pp. 355-370.

sistent withdrawal behavior, but is more emotional and more vigorous in resisting his breakdown.

As a sequential process, the onset begins with somatic and emotional symptoms as in any personal conflict, although the conflicts are, of course, more profound and intense. All patients were harassed and disturbed and some recognized differences in their behavior. Many, however, were not aware that they were breaking down; for they were primarily concerned with isolated symptoms from which they tried to escape. Some also began to disregard some of their needs and to make self-disparaging remarks. When the subjects could no longer contain their tensions they became abruptly explosive or violent in a futile effort to do something about their condition and to reorganize themselves. It was then that the psychotic personality changes set in. Consider the following case:

According to the family, the night before admission the patient started screaming during a thunderstorm, could not be quieted and began to tell the different fears he had in his life. His brothers brought him to the Veterans Clinic for examination and arrangements were made for an interview. The next night, however, the patient again awoke and seemed so frightened, screamed so loudly that the family decided to hospitalize him.

According to the patient, he had noticed changes in himself some 5 months before. The home was overcrowded and he felt that he couldn't study. Instead of arguing with the family, he studied as best he could, but was unsuccessful and merely paced the floor. When he could contain himself no longer, he would burst out crying. He became increasingly tense, and to every request that his family made, he said, "I've got to study." In addition, his family wanted him to quit school so he could contribute to the support of the family, which he refused to do. He was worried about his school work. Having taken a pre-medical course, he was in conflict as to whether he would get through and whether he should continue. At this time he was introduced to a Mr. C. who talked to him about the virtues of becoming a vegetarian. This was a vital decision to him, and he decided finally to become one. In this way, although he did not admit it consciously, he absolved himself from having to strive to go to medical school; but in this process he felt very indecisive and felt that he had to lean on someone. He began to neglect his appearance, and when his brother told him to get some clothes he had no patience to do so. He asked his sister about it and she seemed to ignore his question. He then flared into an uncontrollable rage. Finally, he was intensely hostile and guilty about his mother. The mother apparently had periodic seizures and at no time was she to be

left alone. One-half year before the onset he was told by the family members to stay home with her, but left against their explicit instructions. While he was away the mother had seizures and was severely hurt. He had feelings of intense self-approach which he repressed. These attitudes were somehow revived at this time by a scene in a motion picture, "Knock on Any Door," which he saw the week before he had his outburst. In this scene the hero forsook his girl, who became ill and died. This scene terrified him. He felt at that time that there was a force against him which he could not control, and he experienced peculiar sensations through his body. He felt, too, that he was getting smaller and smaller. On the night of the outburst he saw two eyes—his mother's—coming toward him. In terror he indicated that, "I blew my top and started crying, 'Help, Help.'"

The detection and social definition of the psychotic behavior was done usually by the family, and usually after the onset. Forty-eight patients were committed by some family member, and five patients were committed by non-family members. It is difficult to ascertain accurately this time differential between the onset and the commitment, but it seemed to range between one month and five months.

The expression of their disorder reflected different periods during or after their breakdowns. The physical complaints which occurred in 9 cases, and the vigorous acting-out of the conflicts, as attempted suicide in 11 cases, or assault upon others in 12 cases, usually happened during or soon after the breakdown. Seclusiveness and withdrawal, as shutting oneself in a room, staying in bed, and refusal to go to work, noted in 7 cases, happened during or after the breakdown. The bizarre behavior which was noted in 14 subjects was reaction to disorientations and to hallucinations.

These discrepancies resulted because the families defined psychotic behavior differently. Some families overlooked or at least sought no medical attention for physical complaints, which they believed would clear up. Other families put up with periodic emotional outbursts. A third group permitted seclusive behavior for a short time until the person became bizarre and uncontrollable. In brief, the family definition of psychotic behavior was not uniform, and was not at all synonymous with the onset.

DURATION OF THE DISORDER

By December 1, 1949, of the fifty-three subjects, 43 who had been committed before July, 1948 were followed up. Thirty-eight

of these subjects had been released. Their average length of hospital stay was 6.2 months and ranged from 1 month to 20 months. Yet of these patients 4 had been returned. This period is in marked contrast to the national average of length of hospitalization for schizophrenics who die in the hospital, which in 1943 was 14.6 years;²³ or to the length of stay of schizophrenics in one state hospital in which two-thirds were hospitalized for five years or longer.²⁴ It is in marked contrast to the average hospital stay for schizophrenics as computed by Dunham and Meltzer, who found that the average hospital stay for catatonics was 50.60 months; for paranoids, 60.03 months; and for other schizophrenic types, 57.85 months.²⁵

Of the five subjects who were still in the hospital, one did not want to leave because he did not want to return to his aunts. Of the four other patients, one had improved slightly and would very likely be discharged unless unforeseen relapses occurred, and three had become worse. One female patient was in an agitated condition, and the other two patients had not responded to treatment thus far.²⁶

To what extent, however, does discharge and/or social recovery denote actual recovery? Generally, because of the overcrowded conditions in hospitals, some patients may be released prematurely. Also the wishes of the guardian and of the family may play a minor role in facilitating the release of some patients. But even with these considerations we found that the veterans who were housed in separate quarters which were not overcrowded, and who were not affected by a pressure for discharge, remained even a shorter period than the average subject, about five months.

The criterion of releasing patients seems to be, in the words of a psychiatrist, an "ability to get along in the world." Those patients who were communicative and cooperative, who were self-

²³ "Patients in Mental Institutions, 1943," *U. S. Department of Commerce, Bureau of the Census*, Washington, 1946, p. 29.

²⁴ S. K. Weinberg and H. W. Dunham, "Personality and Culture in the Mental Hospital," Unpublished Manuscript.

²⁵ H. W. Dunham and B. Meltzer, "Predicting Length of Hospitalization of Mental Patients," *The American Journal of Sociology*, 50 (1946), 126.

²⁶ Sullivan points out that the experiences encountered by the schizophrenic during his psychosis may affect his improvement. "Whether one shall continue to be typically schizophrenic or not is, I believe, wholly determined by situational factors." Harry Stack Sullivan, *Modern Conceptions of Psychiatry*, Washington: William Alanson White Psychiatric Foundation, 1945, p. 74.

controlled and who did not manifest psychotic symptoms were considered eligible for discharge. This kind of social recovery in some instances meant actual recovery, insofar as no ideational distortions and no conspicuous apathy were evident. Other subjects seemingly had lingering ideational distortions, which were, however, very subdued and controlled, but they did not have an insidious and persistent type of emotional disinterest, as characterizes chronic schizophrenics.

A SOCIOLOGICAL HYPOTHESIS OF SCHIZOPHRENIA

How does the development of this schizophrenic type fit the theories of schizophrenia? Although hypotheses of schizophrenia have evolved from the chronic type, can an hypothesis be formulated which fits both the transient and the chronic schizophrenics? ²⁷ The sociological hypotheses of schizophrenia concentrate primarily upon the theory of isolation. There are, however, varied interpretations of the isolation phenomenon, and the developmental stage in the schizophrenic process in which it occurs whether in the process of development or just prior to the breakdown. According to one version, schizophrenia results from "any form of isolation which cuts the person off from intimate social relationships for an extended period of time." ²⁸ The bizarre behavior emerges after the

²⁷ The advocates of biogenetic theories of schizophrenia recognize the differences between the chronic and transient schizophrenics. See R. G. Hoskins, *The Biography of Schizophrenia*, New York: W. W. Norton and Company, 1945, pp. 72, 73; J. M. Nielsen and G. N. Thompson, *The Engrammes of Psychiatry*, Springfield, Ill.: C. C. Thomas, 1947, p. 215. Some psychoanalysts have also recognized these different developmental processes. For example, Sullivan refers to the chronic type as dementia praecox and to the transient type as schizophrenia. See Harry Stack Sullivan, *op. cit.*, pp. 71-73. Whether the schizophrenic disorder is a function of shocking experiences in early life as maintained by many psychoanalysts has not been supported by this inquiry in which the subjects appeared rather normal during childhood; and whether the schizophrenic disorder is a regressive psychosis as maintained by many psychoanalysts has been challenged by Cameron at least in the sphere of thinking. See N. Cameron, *The Psychology of Behavior Disorders*, New York: Houghton Mifflin Company, 1947, p. 492, also N. Cameron, "Deterioration and Regression in Schizophrenic Thinking," *Journal of Abnormal and Social Psychology*, 34 (1939), 265-270.

²⁸ R. E. L. Faris, "Cultural Isolation and the Schizophrenic Personality," *American Journal of Sociology*, 40 (1934-35), 456.

individual fails to establish intimate relationships.²⁹ Though isolated behavior is necessary for the explanation of this disorder because it provides the social framework in which schizophrenia may occur, it is not sufficient. In fact, as we have shown, some subjects became more compulsively sociable before the breakdown. First, these schizophrenics were not what would be called shut-in "seclusive" types. But some were isolated from the persons or from the cultural skills in those areas of behavior in which their conflicts were to become most intense and threatening. Second, they participated in intimate groups until the very onset of the disorder. Third, it was not the isolation but the meaning and reaction to isolation that bore most significantly upon eventual schizophrenic behavior. This became especially pertinent in the disruption of such intimate contacts as courtship or marital relations. Thus, personal isolation becomes significant only as it reflects upon the person's irreconcilable and unbearable conflicts, and it cannot be understood without these conflicts.

These conflicts are so unbearable because they are so self-involving. The schizophrenic regards himself as a failure and/or completely loses confidence in his ability to manipulate his environment. The eleven subjects who attempted suicide exemplified this effort to destroy a reproachful self-image. The others who acted out against their relatives, spouses, and other persons regarded this behavior as a random bid for regaining their self-esteem.³⁰ The crucial forms of isolation among schizophrenics emerge from the following personal experiences: (1) They reject the self-image but strive for self-acceptance and social acceptance; (2) they are unable to communicate their conflicts to other persons, or do not have accessible persons to whom they can communicate their conflicts; and (3) they resort to withdrawal as a medium of self-protection. This withdrawing process is not merely a segregating

²⁹ *Ibid.*

³⁰ Boisen states: "The examination of the causative factors in [schizophrenia] has led us to the conclusion that the primary evil lies in the realm of social relationships, particularly in the life situation involving the sense of personal failure. We have found one characteristic common to the group as a whole; they are isolated from their fellows through a social judgment which either consciously or subconsciously they accept and pronounce upon themselves. . . . The result is an intolerable loss of self-respect." See A. T. Boisen, *Exploration of the Inner World*, Chicago: Willet & Clark Co., 1936, p. 28; also Bingham Dai, "Personality Problems in Chinese Culture," *American Sociological Review*, 6 (1941), 693.

process, but rather a disruption in role-taking. For the disruption in role-taking has a protective effect upon the schizophrenic insofar as it spares him from accepting the evaluations of others and looking back at himself. This disruption in role-taking and in self-reference is basic to the subsequent disorientations and false extrapolations which Devereaux has emphasized,³¹ for disoriented behavior means that the psychotic is unable to shift his perspective and share the perspectives of others.

Though chronic schizophrenics also tend to respond in this way, their reactions to unacceptable self-evaluations are not as intense as among transient schizophrenics. The chronic schizophrenics seem more likely to accept the lowered verdict of themselves and to re-adjust to it. The transient schizophrenics do not accept this lowered self-verdict but fight it, and in this fight are more likely to achieve the kind of personal reorientation which makes the disorder relatively brief and improvement come relatively quick.

³¹ George Devereaux, "A Sociological Theory of Schizophrenia," *Psychoanalytic Review*, 26 (1939), 315-342.

Reflections of Social Disorganization in the Behavior of a Schizophrenic Patient *

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ALBERT RITTER, a single, unemployed commercial artist, was committed to a state hospital for mental diseases and given a diagnosis of schizophrenia. During his stay in the hospital he was known as the most violent patient in the "violent ward." The patients in the ward agreed that he was "the craziest one here."

The purpose of this account is to describe, in this particular case, the manner in which the psychotic disturbance derives its content from the social environment in which Ritter lived. This does not, of course, account for the cause of the psychosis itself, for the strength of the mental integration is a major factor; but it may account to some extent for the speed of the process. Primarily, the history of Ritter is presented to show merely how the abnormal person draws on his chaotic experiences and interprets them in his symptomatic behavior. In this case the behavior can be related to Ritter's conception of a solution to all of his severe life-problems. This was not a satisfactory solution; but for a time it seemed to him to answer his need, and he embraced it enthusiastically. But, since it could not be understood or tolerated by other persons, it necessarily involved him in difficulties, including the confinement in a hospital; and consequently his enthusiasm for it declined and his behavior made a progressive change toward normality. After a few months he was permitted to leave the hospital, although he was not presumed to have fully recovered.

SYMPTOMS LEADING TO COMMITMENT

Ritter was twenty-eight years old at the time of his commitment to the hospital. He was taken there by his brothers, acting on the

* From *American Journal of Sociology*, 50 (September, 1944), 134-141. Reprinted by permission of the author and the publisher.

advice of the family physician. The behavior which led to this advice and commitment had developed within the previous week. Albert had first displayed noticeable abnormality one January day in the early 1930's, when he irrelevantly, and with a mysterious grimace, said to his older brother: "Tomorrow the secret will come out." His brother asked what secret he had in mind, and Albert replied: "Oh, the Shadow knows."

That same afternoon he began to write, explaining that he was working on a book—a philosophical system. He worked through the afternoon and evening, interrupting himself twice to attempt to call on two famous men who lived in the vicinity to tell them about some new ideas. The following night, Saturday, while taking a girl to a party on a streetcar, he declaimed in a loud voice to all the passengers on the car, informing them of his new philosophical system. The girl he was escorting thought he was merely showing off; and, when he continued in this manner at the party, it was also assumed by the other guests that he was joking.

Sunday morning he arose at eight, after less than five hours of sleep, and intensively resumed writing on his new "book," sweeping each sheet of paper to the floor as he finished with it. To the members of his family he claimed to see his father, who had been dead for twelve years, coming to him, and claimed also to possess some new and remarkable powers. He asserted in a matter-of-fact voice that he was Christ and that he had developed a new system of thought which would save the world. He spoke of broadcasting his ideas to Marconi. He persisted in discussing his new system with his older brother far into the night.

On Monday morning the family doctor was called and came to the apartment. In order to avoid arousing Albert's suspicions, she perfunctorily examined each of the sons. The oldest brother then mentioned that Albert had a "philosophical idea." Albert said: "Yes, I'm Jesus Christ." On her advice he was taken to the hospital that morning, where he began to act in a fairly violent manner, shouting his new ideas and demonstrating some fantastic new powers to all persons in sight.

SUMMARY OF THE LIFE-HISTORY

Albert was the second of six sons, five of whom survived. The father was a tailor and during the years of Albert's childhood lived in a low-rental area of a large mid-western city. George, the oldest

son, was the mother's favorite; and she did not desire to have any more children and hence partially neglected Albert, who became a favorite of the father. The attachment between Albert and his father grew very strong and lasted until the death of the father, in Albert's seventeenth year.

Albert's childhood was not exceptional, as far as can be known. He had a poor school record except during the periods when he had particularly sympathetic teachers; but he developed a strong interest in reading during his childhood, and later an interest in painting. He studied at an art school and eventually earned his living through commercial art. In this career he progressed well; and his earnings steadily increased, reaching a peak while he was working in Florida during the 1926 real estate boom. At this time he associated with persons of a "bohemian" type and drank and spent freely. He justified this behavior as appropriate to an artist's life.

Following the collapse of the Florida boom, he returned to his home city and began to experience difficulty in earning money. When the 1929 depression arrived, he was unable to find work and had to live with his older brother, George, who by this time was a lawyer and was supporting the entire family. After a period of halfhearted job-hunting, Albert eventually resigned himself to staying about the apartment, reading and idling. He had to be content with the small amount of pocket money George could give him.

At the parties he attended on occasional evenings, he regularly became intoxicated. He was encouraged to do this by the men at the parties, for they enjoyed the antics of a drunkard. At one time, following the insistence of his mother, he made an attempt to abstain from liquor; but after a few months he was persuaded to have a drink at a New Year's Eve celebration, and from that time on he continued to drink to excess.

Albert fell in love with a girl who did not reciprocate but who developed an infatuation for one of his younger brothers. As this and the other problems accumulated, he applied himself increasingly to reading popular works in philosophy, science, religion, and other literature in an effort to find solutions to his perplexities. In his twenty-ninth year, a few days before his commitment to the hospital, his brother, George, put into his hands a book which seemed to Albert to resolve all his problems at once. In his feverish adoption of a "new system" inspired by the book, his behavior became so excited and unconventional that it was not to be tolerated outside of an institution.

MAJOR CONFLICTS AND PROBLEMS

In the course of Albert's life there arose a number of conflicts and problems which were a great source of torment. These tore at his mind in a variety of ways. The confused mores in his culture, the contrasting groups to which he held partial loyalty, and the inconsistencies of promise and achievement in his career—such elements form the contribution of social disorganization to the personal disorganization he was suffering. His behavior during the period of his psychosis represents an adaptation to these problems. It was a poor adaptation, since it did not fit him to survive in the competition of the contemporary civilization; but it was organized and for a time seemed to promise better things.

His new system of psychotic thought and the apparently incoherent speech and writing by means of which he expressed it are organized about the following major problems.

1. There was a strong homosexual attachment to his father and a sense of guilt connected with it. Albert had a feeling of being lost after the death of his father and never succeeded in finding anyone else toward whom he could have such deep affection.

2. He had acquired in his youth a violent anti-Semitic prejudice, only to discover in his adulthood that his family was of Jewish descent.

3. He had acquired a strong moral objection to commercial art, which he considered "prostitution" of his talent; but he could earn his living only by means of that kind of art.

4. By virtue of his reading, especially such romantic reading as Edgar Allan Poe, whom he admired above all other authors, he came to dramatize himself; but he could not succeed in getting others to accept him in these romantic roles. His acquaintances assumed he was joking or showing off and merely laughed at him.

5. During the first part of his career his economic success was satisfactory and rapid, and within five or six years after his start he was earning as much as \$400 a month and had plans for projects which he hoped would carry him further. His failures after the collapse of the Florida boom and in the later major depression gave him considerable torment.

6. In addition to some homosexual experiences of early years, he had two kinds of love for women. He had experienced normal heterosexual relations with some of the "bohemian" girls he met

at parties and, in addition, experienced a distant and romantically wistful sentiment for a pale and fragile girl, Gladys Brown, whom he worshiped fervently from afar. He considered her somewhat inaccurately, to be a fine, spiritual type, deserving of worship; and he believed that he was not worthy of her and yet desired to be loved by her. He drew an analogy between himself and Poe, who wrote of similar forms of love.

7. Albert had a severe internal struggle concerning his addiction to alcohol. His mother and also Gladys Brown exerted strong pressure against his drinking habit; but his friends offered liquor and encouraged him to drink heavily, and he did not have enough will power to refuse. Gladys crushed him severely with a reaction of disgust to his boisterous and obscene antics; but he was, nevertheless, unable to break his habit.

It is through these problems that the connection between Albert's abnormal behavior and social disorganization is to be found. Not only does the anti-Semitic conflict develop in a situation of cultural heterogeneity but it also reveals that his family had taken the step of desertion of the ancestral group somewhat furtively, in the manner of Negroes who "cross the line." The confusion of moral values is visible in his conflict over commercial and fine art and in his mixed attitudes about love for women. The instability of his economic status is connected with the unsettled place of art in our urban civilization and even more, of course, with the economic disorganization of the booms and depressions which so directly affected Albert's career. His conception of his status was derived not from a harmonious social group of which he was a primary member but rather from distant and mixed sources and partly derived from his reading and day-dreaming. He could not find a group which would accept this self at face value, and he did not find a group in which he could achieve an integrated and harmonious personality. He sought for friendship and love; but his personality was made of components which were assembled from a variety of sources, and no social group could be found to understand and accept it.

Such disorientation is most likely to be found, as in this case, in a heterogeneous, changing modern city. Albert was, in a sense, lost, since he was culturally marginal in several respects. The marginality did not directly produce abnormality; but in these circumstances he suffered from the inability to find integration of self and society,

except during the early period of his psychosis, when he found an answer that temporarily was attractive to him.

CATASTROPHIC RESOLUTION OF THE CONFLICTS

An imperfectly integrated social order formed the background for the development of this disintegrated personality, which was imperfectly assembled from aspects of the social order which are in conflict with one another and are productive of conflicts within the person. The conflicts produced in Albert internal strains and an intolerable sense of being internally divided. His psychotic behavior and writing show that he felt tormented by this feeling of possession of a dual nature. There was, however, no such easy solution as to renounce the lower aspects of his self and embrace the finer elements, as there was no such convenient division or classification. Some of the lower or baser aspects were associated with his still powerful affection for his father, and yet Gladys exerted a strong pull on the other side. In the anti-Semitism conflict there was no escape from his origins. In such a question as the liquor conflict he knew that he did not have the will-power to change. The self that he dramatized as being like Poe was perhaps thought destined to be tragically weak for some unknown and exalted purpose.

The solution he found, while undesirable from the point of view of survival in society, did have a logical relation to the nature of Albert's particular problems. It did not demand a change that he could not make. It resolved the conflicts so that he could have unity in his character without pulling himself out of trouble by his bootstraps. An internal war thus came to a sudden end, and the conflicting elements temporarily came to rest.

The solution that brought this sense of peace was suggested by a minor philosophical work entitled, *A Night in Luxembourg*, by Remy de Gourmont. The author, a nineteenth-century writer, makes use of a fantasy to present some of his outlooks on life and the universe. In the edition read by Albert a biographical note gave information about De Gourmont, who had some of the traits of Poe—the interest in the fantastic, unconventionality of behavior, and struggle for self-control. Albert immediately noticed a parallel with his own character and read the book with strong

personal interest, which grew into excitement as he proceeded. Before he finished, he had decided that he had found the system which would solve his problems. If there can be said to be a point at which a psychosis begins, this moment of decision, in which he embraced a thought which was to be expanded into a major pattern of insanity, may be regarded as the crucial moment.

In the De Gourmont fantasy, a character named Sandy Rose wandered into the Luxembourg garden at the invitation of a mysterious and fascinating stranger, who soon revealed himself to be Christ. During their lengthy conversation this unconventionally described Christ revealed to Sandy Rose a new outlook on life and informed Rose that he had chosen Rose to be the intermediary to carry this new truth to mankind.

One of the central ideas, and the one which enormously impressed Albert and formed the basis of his solution, is that there is nothing essentially evil in the nature of man and that to follow one's natural impulses and not be bothered by the complexities of moral thought and guilt was the way to truth and happiness. Some beautiful goddesses were present, and through them love and sex were presented as a part of the natural, and therefore the divine, nature of things. Shame and moral conflict and puritanical notions about the nature of man were ruled out by the unconventional Christ, who pointed out that "I am a man, and God is a man."

Virtually the entire content of conventional Christianity was dismissed, and in its place was recommended: "To make a system that should have some distant relation to the truth, the cinematic philosophy of Epicurus would have to be poured into the fables of pagan mythology." This statement was heavily underlined by Albert. He wrote in the margin: "This is the Key!" and "A system is now made which is the Truth, Albert C. Ritter, January, 19——." Below he wrote, in capitals: "DE GOURMONT A PROPHET WHO IS CLEAR REASON." Throughout the book there were many underlinings and marginal comments, indicating the emotion with which Albert read it and the depth of its impression on him. At one point the Christ said: "But these ideas can scarcely, I think, bring you much consolation." Albert underlined it, and wrote: "Perfect Consolation." There was only one point at which Albert indicated dissent from the advice. The Christ told Mr. Rose, now that he possessed this great knowledge, not to lose his balance but to submit outwardly to customs, prejudices,

and tradition and to set his step to the rhythm of the popular mind. Albert, who had by this time made his decision and thereby entered his psychosis, wrote: "No! This is hypocrisy."

The effect on Albert of the discovery of De Gourmont's system was to start a far-reaching process of reorganization in his mind. He had to reinterpret himself, his family, his friends, and the world he lived in. He felt compelled also to do that which Mr. Sandy Rose had been told to do—to take the new system to mankind and thereby to end all the troubles of the human race. He accepted a supernatural interpretation of the fact that it was he who was to bring this great improvement to the world, and so decided that he could only be Christ. Now his unhappy past had a new meaning, for it could now be seen as the necessary suffering he had been compelled to go through so that he could lead all humanity out of its miseries.

The frenzied writing which occupied the three days preceding his commitment was an attempt to write down this new system and to think through its consequences so that it could be given to the world. In his excitement he wrote with great haste, and, though there were connected sections, there were also sharp breaks, as his mind would turn to other subjects and new ideas would crowd into his mind. There were notes and jottings to remind him to read up on various subjects and to include discussions of specified ideas. He felt an urge to give out the news at once and wrote a letter to the long-dead De Gourmont and another to a local newspaper. He also attempted, without success, to secure interviews with some prominent men who lived in his vicinity.

To De Gourmont he wrote:

I should like to hear from you and, if possible, meet you. I have discovered the "System" you refer to in "Une Nuit au Luxembourg."

You are a Great Prophet!

You have said this system will come from "Epicurus and Pagan mythology."

It has come from M. de Gourmont first! Is this not an astounding concatenation of Events?

I am an obscure painter.

Will you write?

Great Pan is Re-born!

Love.

ALBERT RITTER

P.S. I am 28.

As he wrote, his ideas expanded; and, instead of only one book, he now conceived of a series. At the beginning he wrote some titles:

The Secret of Life—And the Key to the Secret
 This is the New Age of Reason and Thought in Man
 The Root of Knowledge (Title of Series)
 The Root of Knowledge is Clear and Perfect Reason

Couplet. Who in this cover Inconsistency finds
 Remembers that Janus had two minds

Title of this Book I is
 "The Formula of Clear and Perfect Reason"

Chapter I
 The Secret of Life

The Secret of Life is Love.

Nature has borne me so that I may forever enlighten the minds of men.

The Secret of Life is in Life.

I am her medium. Through the Love of Woman and all Mankind I have awakened.

Through Remy de Gourmont, Epicurus, and the God Pan I have awakened.

I have come to set the mind of man at Rest. Through me he will find the Love he seeks—the Happiness he never finds.

This Love is the Love of the Useful and Beautiful in Life, in Nature.

This, my brothers, is the Formula by which, if you are Willing, you will find the happiness you Desire. This is the New Age of Reason and thought in Man and I am your Leader. Follow me.

I am Jesus Returned.

Albert's writing was too hasty to be orderly; and he scribbled out his ideas, with sentences and punctuation incomplete, in whatever form they came into his thoughts, so that they would not be lost. Selected statements from these writings show how they applied to his special problems and experiences.

This is the End of the Bloody Revolution of Thought. Liberty Forever!

The World Forever!

This is the End of Ignorance and of Viciousness, of Vanity, of Greed, of Lust for Power, of Crime.

This is the Beginning of Love!

For Vicious Nature has been Conquered by Love and Man.

Nature has Submitted to Man. . . .

There will be no Laws among Perfect Men Except the Law "Know Thyself."

There will be no Injustice. . . .

There will be no Immigration Laws for the Love of Man for Man is most Powerful. There is Room for all on Earth. . . .

All men are Jews

All women are Jews

All children are Jews

Jews Control the World, and Nature

Jews Control the Cosmos. . . .

There will be no Rise and Fall of Cities, for there will be no Wars!

There will be no Economical Depressions!

There are no Gods in Heaven

Heaven is on Earth. . . .

My Struggle and My Father's Struggle. . . .

Edgar Allen Poe, the World's most Beautiful Soul. He Recognized Sad Beauty in woman Nature's Ideal. . . .

The Bloody War is over!

Truth Reigns King!

I am Perfect Man. I am Truth in Man.

The Struggle I had was Bitter but I have Conquered Myself.

I was Imperfect Man Myself before January 21, 1931, the Day of the Metamorphosis of Man!

Man shall likewise Feel but one Nature within him. One Truth, the Truth of Clearness and Perfection of Reason which he will find in Woman who in turn will Show Him how to find it in Man and Nature.

Then Everything and Everybody will be Happy.

Then Everything and Everybody will be Beautiful

Then there will be no Death

Every Day shall be a Holiday

There will be no Fear. . . .

There is No Fear (Great General Truths)

The Fear of Death is an Illusion.

Question: Is Death Terrible and Fearful?

Answer: No—Death is Beautiful as All of Nature is Beautiful, and Life itself is Beautiful as all of Nature is Beautiful.

Question: What is the Fear of Death?

Answer: The Fear of Death is Ignorance. We Fear that which we do not Understand, which is Ignorance.

Question: How can man Conquer the Fear of Death?

Answer: We Conquer the Fear of Death the Same Way we Conquer the Fear of Life and its Vicissitudes and Sorrows—by Clear and

Perfect Reason which understands Everything, Consequently Fears Nothing, thus we are Happy because we Love and do not Fear. Love is All Powerful. Fear exists but in Ignorance which is mastered by Clear and Perfect Reason. There is no Fear. (Great General Truths Pile).

BEHAVIOR IN THE PSYCHOSIS

During his first few weeks at the hospital Albert's conduct was conspicuously abnormal a large portion of the time. He continued to think through more consequences of his system, contemplating new benefits to humanity and imagining new powers that he was acquiring. Whenever gifts of cigarettes and candy were brought to him by members of his family, he distributed these possessions immediately among the other patients in the ward. This practice was not followed by the other patients; and some of them even considered it comical, but Albert conceived that in his new system all men were to be as brothers and that private property and all forms of selfishness were to disappear.

Among his new powers Albert claimed superhuman strength, fortitude, and feats of thought and will. He demonstrated his ability to be indifferent to pain by striking himself on the forehead vigorously with the palm of his hand and by burning his flesh lightly with a cigarette. He also claimed the ability to digest anything, stating that "my stomach is made of concrete." He asserted that he could stop a speeding car or a bullet coming in his direction by holding out his hand. He claimed to be able to understand any language and made attempts to demonstrate this ability. He further asserted that he was able to assume any desired character, and he supported this statement by means of crude impersonations of Apollo and John Barrymore. These abilities were among the benefits of his new-found system of thought, and he asserted that others could acquire them as he had done.

Albert could at any time, and frequently did, converse in a calm and normal manner about ordinary topics. Unconventionality of expression appeared only when some aspect of the new system became involved in his thoughts. Frustrations were irritating to him, however; and challenges of his statements concerning the system were intolerable. His violent rages occurred when he thought he was being opposed by someone; and, since both real and imaginary opposition was frequent, he became the most unquiescent patient in

the ward. Not only other patients and attendants, who were tactless in their skepticism concerning his contentions, but even the members of his family, who were embarrassed and shocked by his behavior, would drive him into a rage. Albert was in the position of a man who suspects himself to be the great savior of his era but who fails to find a single believer or follower.

In addition to these frustrations, there was still another basis for Albert's despair. His hospitalization was inevitably a surprise and shock. When his brothers first visited him, he accused them of "railroading" him there. This was no delusion, as they had made use of trickery to get him behind the locked doors.

But, despite these provocations, Albert had the ability to control his behavior when there was obvious necessity. When a visit from Gladys, his "ideal" girl, was arranged on the condition that he speak quietly and sensibly and without reference to his "system," he observed the requirements during the entire hour of her visit. During the later period of his hospitalization he gradually learned to keep his new ideas to himself, since he came to realize that no one was interested in them. When he asked a trusted friend to help him be released from the hospital, he was advised that he would have to cease his unconventional talking and behavior for some weeks. He began to do so almost at once and was set free after about four months of hospitalization. His behavior at home appeared normal except for a tendency to quietness. After several weeks, however, situations occurred which aroused some of his old conflicts, and some of the abnormal symptoms began to reappear. His brother arranged to send him to a small town some distance away from the city. It was learned that after a time he had to be committed to a mental hospital in this vicinity.

CONCLUSION

In the judgment of all who knew him, Albert Ritter was mentally abnormal; and in the eyes of the law he was insane. It does not seem accurate, in view of the information about his experiences, to speak of his condition as "mental disorder," for it has been shown that he constructed an order more elaborate and symmetrical than is characteristic of most normal persons. His difficulties arise from the fact that his order is unique and private and out of harmony with the shared order of normal persons. As a leader of a sect, in which he could impose his own order on his followers, he might

have had a chance to achieve harmony with other persons. Such an accomplishment, however, though conceivable in other times and places, is virtually impossible among the heterogeneous, mobile, and disorganized urban populations to which he was exposed. In this latter situation persons with such divergent and private mental organizations have no value and can seldom be allowed to be at liberty. The disorganized social system plays a part in producing such marginal and inappropriate personalities and at the same time presents an environment which is severely unsympathetic and inhospitable to them.

A Sociological Theory of Psychopathy*

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It is becoming increasingly apparent in modern psychopathology that one of the most heuristic approaches to the study of behavioral disorders is the consideration of social behavior. It is almost a truism that many psychiatric entities are to a large extent dependent upon sociological manifestations for their detection and definition. Thus, for example, schizophrenia may be referred to as a disorder characterized, among other things, by inappropriate social behavior, defection of interpersonal relationships, and meagerness of emotional response. Paranoia is a disorder in which situations are progressively misdefined, occasioning isolation from the social group and inability to communicate successfully with it.¹

In spite of the interesting possibilities of such an approach, there has been little in the way of formal sociological analysis of the various clinical syndromes.² There have been a number of studies of the ecology³ and of the predisposing or background factors⁴ of mental disease, but the actual conceptualization of these dis-

* From the *American Journal of Sociology*, 53 (March, 1948), pp. 359-366. Reprinted by permission of the author and the publisher.

¹ Norman Cameron, "The Paranoid Pseudo-Community," *American Journal of Sociology*, XLIX (1943), 32-38. (No. 11 in this volume.)

² Besides Cameron's excellent paper, one should list: Robert E. L. Faris, "Reflections of Social Disorganization in the Behavior of a Schizophrenic Patient," *American Journal of Sociology*, L (1944), 134-41. (No. 17 in this volume.) Faris delineates the manner in which sub-group identifications are embodied in the psychotic fragmentation of the subject's personality. Also, the paper by G. Devereaux, "A Sociological Theory of Schizophrenia," *Psychoanalytical Review*, XXVI (1939), 315-42, should be mentioned.

³ Robert E. L. Faris and H. Warren Dunham, *Mental Disorders in Urban Areas* (Chicago: University of Chicago Press, 1939); Robert E. L. Faris, "Ecological Factors in Human Behavior," in J. McV. Hunt (ed.), *Personality and the Behavior Disorders* (New York: Ronald Press, 1944), I, 736-57.

⁴ H. Warren Dunham, "The Social Personality of the Catatonic-Schizophrenic," *American Journal of Sociology*, XLIX (1944), 508-18.

orders in sociological terms has not received much attention.

The present paper is an attempt to apply sociological concepts and the sociological point of view to the psychopathic personality. In order to clarify the present usage of the concept, a brief survey of the development of the concept will be given.

DEVELOPMENT OF THE CONCEPT

Medical historians have generally traced the concept of psychopathy to Prichard.⁵ Prichard classified psychiatric disorders into two broad groups, moral and intellectual insanity.⁶ Moral insanity, or moral imbecility, referred to aberrations of the conative and emotional areas; cases were discussed under this heading which may be taken as prototypes of the psychopath as known today.⁷

The dichotomy was vigorously disputed during the remainder of the nineteenth century, with Isaac Ray probably its ablest American defender.⁸ The Guiteau trial in 1881 brought the controversy into relief: the exoneration of President Garfield's assassin was sought on the basis of "moral insanity."⁹ The contradictory testimony of eminent physicians and alienists led to a repudiation of the concept of moral imbecility.

Various deficiencies in Prichard's treatment were also discovered. Thus, Tredgold now contends that unrecognized cases of mania and early paresis were mistakenly included among the moral imbeciles.¹⁰ The concept became increasingly untenable, and its usage ended about 1900.¹¹ At this time the designation "psycho-

⁵ G. E. Partridge, "Current Conceptions of Psychopathic Personality," *American Journal of Sociology*, XLIX (1930), 53-99; D. K. Henderson, *Psychopathic States* (New York: Norton, 1939), p. 11 (as Henderson states, the term "psychopathic inferiority" was introduced by Koch in 1888 (p. 17); S. Maughs, "A Concept to Psychopathy and Psychopathic Personality: Its Evolution and Historical Development," *Journal of Criminal Psychopathology*, II (1941), 329-56 and 465-99.

⁶ J. C. Prichard, *A Treatise on Insanity* (London: Gilbert & Piper, 1835), pp. 6-7.

⁷ D. K. Henderson and R. D. Gillespie, *A Text-book of Psychiatry* (6th ed.; London: Oxford University Press, 1944), p. 382.

⁸ Arthur E. Fink, *Causes of Crime* (Philadelphia: University of Pennsylvania Press, 1938), p. 52.

⁹ *Ibid.*, pp. 69-73.

¹⁰ A. F. Tredgold, *A Textbook of Mental Deficiency* (6th ed.; Baltimore: W. Wood, 1937), p. 333.

¹¹ Maughs, *op. cit.*

pathy" was taken up, and it continued in ascendancy up to around 1924. The emphasis in this period was primarily on constitutional factors and genetic etiology. At the present time there has been a shift to a more dynamic interpretation, particularly as manifested in the psychoanalytic formulations.¹²

Although the question of etiology is still a polemical one, there is fair agreement concerning symptomatology. Preu's definition is representative:

"The diagnostic labels *psychopathic personality* and *constitutional psychopathic inferiority* designate those individuals who have manifested considerable difficulty in social adjustment over a period of many years or throughout life, but who are not of defective intelligence nor suffering from structural disease of the brain or epilepsy, and whose difficulties in adjustment have not been manifested by the behavioral syndromes which are conventionally referred to as neuroses or psychoses."¹³

Other writers stress similar aspects in most cases. For example, Henry mentions defects of emotional control, inability to profit

¹² There is still an influential body of opinion in psychiatry behind the genetic interpretation of psychopathy (see, e.g., S. B. Maugh's, "A Concept of Psychopathy and the Psychopathic Personality," *Journal of Criminal Psychopathology*, III (1942), 494-516 and 664-714; and Paul W. Preu, "The Concept of Psychopathic Personality," in J. McV. Hunt (ed.), *Personality and the Behavior Disorders*, p. 928). H. F. Darling, "Definition of Psychopathic Personality," *Journal of Nervous and Mental Diseases*, CI (1945), 121-26; and G. E. Partridge (*op. cit.*) assign greater weight to environmental factors. An incisive developmental analysis is given by Lauretta Bender, "Psychopathic Behavior Disorders in Children," in R. M. Lindner and R. V. Seliger (eds.), *Handbook of Correctional Psychology* (New York: Philosophical Library, 1947), pp. 360-77.

¹³ *Op. cit.*, p. 923. Preu is highly critical of the concept, feeling that its persistence in psychiatry is not purely a function of its intrinsic usefulness; rather, its retention may be attributed to, first, its constitutional implications which subtly reject modern environmentalistic trends; second, it is a convenient euphemism when a diagnosis of frank psychosis is inadvisable; and, third, it has a forensic utility in establishing a transition zone between wholly complete and incomplete legal responsibility (pp. 929-30).

Others have also objected to the concept recently. J. E. W. Wallin, "Questions and Answers: Mental Deficiency, Psychopathy, and Delinquency," *Journal of Criminal Law and Criminology*, XXXVI (1945), 116-20, states that psychopathy is not a definite nosological entity; and David Abrahamsen, *Crime and the Human Mind* (New York: Columbia University Press, 1944), p. 110, claims that the concept has tended to obscure personality analysis.

from experience, impulsiveness, and lack of foresight.¹⁴ White suggests an inadequate superego development which leaves the person unable to control the powerful instinctual drives or to modify infantile standards of conduct.¹⁵ Diethelm emphasizes the lack of self-reliance and unsatisfactory adjustment to the group,¹⁶ whereas Caldwell indicates nomadism, inability to withstand tedium, and irresponsibility as characteristics of psychopathy.¹⁷

Karpman has objected to the use of psychopathy merely as a synonym for delinquency.¹⁸ He states that, when there is a true lack of ethical and moral principles in the personality, the term "anethopathy" should be used.¹⁹ In a later paper, Karpman distinguished between idiopathic (primary) and symptomatic psychopathy.²⁰ In the former there is a distinctive personality configuration, but in the latter there is only fortuitous and sporadic antisocial behavior. Lindner feels that the crucial factor is an inadequate resolution of the Oedipal situation.²¹

Cleckley has contributed one of the most searching accounts of this protean disorder.²² Present legal and medical conceptions are both inadequate, Cleckley contends; the asocial, impulsive psychopath can escape legal retribution for his delinquent acts by pleading insanity and then, after the briefest commitment, can secure release by establishing psychiatric competence. Because of this state

¹⁴ G. W. Henry, *Essentials of Psychiatry* (3d ed.; Baltimore: Williams & Wilkins, 1938), p. 223.

¹⁵ W. A. White, *Outlines of Psychiatry* (14th ed.; Washington, D.C.: Nervous and Mental Disease Publishing Co., 1935), p. 374.

¹⁶ O. Diethelm, "Basic Considerations of the Concept of Psychopathic Personality," in R. M. Lindner and R. V. Seliger (eds.), *Handbook of Correctional Psychology*, pp. 384-94.

¹⁷ J. M. Caldwell, "The Constitutional Psychopathic State," *Journal of Criminal Psychopathology*, III (1941), 171-79.

¹⁸ B. Karpman, *The Individual Criminal* (Washington, D.C.: Nervous and Mental Disease Publishing Co., 1935), pp. 182-83.

¹⁹ B. Karpman, "The Problem of the Psychopathies," *Psychiatric Quarterly*, III (1929), 495-526.

²⁰ B. Karpman, "Psychopathy in the Scheme of Human Typology," *Journal of Nervous and Mental Diseases*, CIII (1946), 276-87.

²¹ R. M. Lindner, "Psychopathic Personality and the Concept of Homeostasis," *Journal of Clinical Psychopathology*, VI (1945), 517-21; *Rebel without a Cause* (New York: Grune & Stratton, 1944).

²² H. Cleckley, *The Mask of Sanity* (St. Louis: Mosby, 1941); "The Psychopath Viewed Practically," in R. M. Lindner and R. V. Seliger (eds.), *Handbook of Correctional Psychology*, pp. 395-412.

of affairs, treatment cannot be imposed upon the psychopath as easily as it can on other mental incompetents.

One of the reasons for this cultural lag is the convincing arguments the psychopath can make on behalf of his own sanity and integration. The psychopath can verbalize all the moral and social rules, but he does not seem to understand them in the way that others do. This verbal facade Cleckley has called the "mask of sanity." The characteristic deterioration is called "semantic dementia."²³ The personality in psychopathy is so completely involved that there are no signs of incongruity, of anxiety, or of self-doubting such as can be found in the psychoneuroses, in psychoses, and in criminality. Nor can factors such as mental defectiveness or cranial pathology be specified. It is almost as if the person were a robot of indescribable ingenuity, able to do everything a healthy personality could except to participate in a social group.²⁴

When the various discussions of psychopathy are surveyed, a psychological common denominator is found in a set of attitudes which characterizes the psychopaths as a group. Much of the opposition to the use of the concept refers to the purely symptomatic nature of its definition. However, if a set of attitudes can, in fact, be demonstrated, then there would be some justification for using the diagnostic term "psychopathic personality" with these characteristics as defining properties. Such a concept would enable one to discriminate the adventitious offender against group demands, the intellectually inadequate, etc., from the true psychopathic personalities—persons possessing a characteristic personality configuration.

We may, then, list some of these common attitudes: overevaluation of immediate goals as opposed to remote or deferred ones; unconcern over the rights and privileges of others when recognizing them would interfere with personal satisfaction in any way; impulsive behavior, or apparent incongruity between the strength of the stimulus and the magnitude of the behavioral response; inability to form deep or persistent attachments to other persons or

²³ Wendell Johnson, *People in Quandaries* (New York: Harper & Bros., 1946), writing from the position of general semantics, concurs with Cleckley on this point. The psychopath, says Johnson, cannot abstract in the technical semantic sense; terms are only vaguely discriminated. His sincerity is an illusion, and his social sense only word-deep (*ibid.*, pp. 321-25).

²⁴ Cleckley, *The Mask of Sanity*, p. 279.

to identify in interpersonal relationships; poor judgment and planning in attaining defined goals; apparent lack of anxiety and distress over social maladjustment and unwillingness or inability to consider maladjustment qua maladjustment; a tendency to project blame onto others and to take no responsibility for failures; meaningless prevarication, often about trivial matters in situations where detection is inevitable; almost complete lack of dependability and willingness to assume responsibility; and, finally, emotional poverty.

None of these attitudes or characteristics, taken alone, would be crucial, but, when seen to converge on a particular person, they constitute strong evidence of psychopathy. Nor is any of these factors explicitly dependent upon illegal or asocial behavior; they may easily be inferred from such behavior, however. Thus a person may be characterized by the above factors, that is, be psychopathic, and still not be institutionalized or guilty of illegal acts; but, on the other hand, the psychopaths would be expected to contribute more than their share to the delinquent and criminal populations.

THE PSYCHOPATH AS DEFICIENT IN ROLE-PLAYING ABILITIES

That part of the personality which links an individual to the social community, often referred to as the "self," is a product of social interaction. Baldwin and Cooley were two of the early writers to call attention to this fact; they contended that self-conceptions are in large part determined by the responses of others.²⁵ Mead has given what is probably the most acceptable account of this process.²⁶ According to Mead, the rise of the self depends upon the individual's capacity to look upon himself as an object. Such self-conception is an assumption of the reaction of others. As Mead states:

"The self arises in conduct, when the individual becomes a social object in experience to himself. This takes place when the individual assumes the attitude or uses the gesture which another individual would use and responds to it himself or tends to so respond. . . . The child

²⁵ James Mark Baldwin, *Mental Development in the Child and in the Race* (New York: Macmillan Co., 1894); Charles Horton Cooley, *Human Nature and the Social Order* (New York: Charles Scribner's Sons, 1922).

²⁶ George H. Mead, *Mind, Self, and Society* (Chicago: University of Chicago Press, 1934).

gradually becomes a social being in his own experience, and he acts toward himself in a manner analogous to that in which he acts towards others."²⁷

The self thus has its origin in communication and in taking the role of the other.²⁸

In Mead's terminology this role-taking gradually becomes integrated into a number of self-conceptions, each of which is called a "me," each corresponding to the definition of the self by others. During this developmental period the child will often talk to himself as others talk to him.²⁹ In time a certain communality and consistency in the patterns permit the evolvement of a conception of the "generalized other,"³⁰ which represents social reality as seen by the self. At this level the personality is able to observe abstract rules and standards, such as occur in formal games.

No matter how thoroughly the societal standards and folkways have been introjected, there will always remain a degree of uncertainty in every expression of the self. This dynamic aspect or feature of the interactive process, as Young has described it, is called the "I."³¹ Hence it cannot be predicted precisely how one will react before the action takes place; the "I" constitutes the unpredictable, the unique, the novel element in thought-processes and in behavior.

The importance of these concepts for social interaction can easily be seen. Adaptation, co-operation, and even understanding are functions of the "me's," of the role-taking experiences. Hence, self-criticism as exercised through the "me's" is really social criticism, and behavior modified by self-criticism is really behavior modified socially. As Lee states, "Without the attainment of a *me* there would be no basis for cooperative enterprise."³²

Whether or not we wish to accept in full Mead's theory and terminology, a clear case is presented for certain fundamental propositions. First of all, the basis for individual sociality is social

²⁷ George H. Mead, "A Behavioristic Account of the Significant Symbol," *Journal of Philosophy*, XIX (1922), 160.

²⁸ See discussion in Ellsworth Faris, "The Social Psychology of George Mead," *American Journal of Sociology*, XLIII (1937), 391-403.

²⁹ Kimball Young, *Personality and Problems of Adjustment* (New York: F. S. Crofts & Co., 1940), p. 169.

³⁰ Mead, *Mind, Self, and Society*, pp. 150-54.

³¹ *Op. cit.*, p. 175.

³² Grace C. Lee, *George Herbert Mead, Philosopher of the Social Individual* (New York: King's Crown Press, 1945), p. 68.

interaction,³³ and this interaction is effective in so far as the individual can look upon himself as an object or can assume various roles. This role-taking ability provides a technique for self-understanding and self-control. Learned prohibitions (and all social interdictions must be learned) may be observed by "telling one's self" not to behave in a certain way. Or speech may be editorially "reviewed" as it is emitted, and the inadmissible deleted. Role-playing, or putting one's self in another's position, enables a person to predict the other's behavior. Finally, role-playing ability makes one sensitive in advance to reactions of others; such pre-science may then deter or modify the unexpressed action.

Now if we take the set of attitudes previously described, it would seem desirable to synthesize them into one or more embracing concepts, just as they themselves emerged (were inferred) from discrete bits of behavior. Role-playing is such a concept. Saying that the psychopathic personality is pathologically deficient in role-playing abilities permits the accommodation of the already known facts about psychopathy and also the possibility of predictions in areas where present knowledge is scant. Such deductions could then be submitted to empirical tests.³⁴ Even without deductive

³³ Cf. e.g., the way "thine" and "mine" proscriptions are learned by the middle-class child: W. A. Davis and R. J. Havighurst, *Father of the Man* (Boston: Houghton Mifflin Co., 1947), pp. 171-72 *et passim*.

³⁴ One such deduction would be that on the "Chapin Test of Social Insight" (F. Stuart Chapin, "Preliminary Standardization of a Social Insight Scale," *American Sociological Review*, VII (1942), 214-25) diagnosed psychopaths would secure lower scores than controls matched for intelligence and education. Another would be that an effective scale could be empirically developed to screen psychopaths from normals by use of questions on the responses of hypothetical individuals and groups in described situations. Such a scale would not need to include any ethical or moral decisions or judgments about what would be "right" and "wrong." It would merely ask the subject to predict what such-and-such a person or group would do under such-and-such conditions.

In using tests, however, one must be careful not to set up a self-contained system whose terms are at variance with those of the culture. Lundberg has clearly shown the futility of arguments about the "essential nature" of concepts such as neurosis or psychopathy, or about what a concept "really is" (George A. Lundberg, *Foundations of Sociology* (New York: Macmillan Co., 1939). The difficulty in using some critical test score as a definition of psychopathy is not that it would be *wrong*, but that the institutionalization of the medical concept requires other users of the term to conform in order to avoid confusion. Actually, what most inventories are trying to do is to *predict the diagnostic behavior of psychiatrists*, and not to establish new meanings for the terms used.

extrapolation of this kind, the concept of the psychopath as one deficient in role-playing ability would be useful to the extent that it resolves and fuses the indeterminate number of descriptive statements, such as those previously made, which could be given.

For our purposes, then, deficiency in role-playing means the incapacity to look upon one's self as an object (Mead) or to identify with another's point of view. The psychopath is unable to foresee the consequences of his own acts, especially their social implications, because he does not know how to judge his own behavior from another's standpoint. What might be called social emotions, such as embarrassment,³⁵ discomfiture, loyalty, contrition, and gregariousness (group identification), are not experienced by the psychopath.³⁶

When confronted with disapproval, the psychopath often expresses surprise and resentment. He cannot understand the reasons for the observer's objection or disapprobation. The psychopath cannot grant the justice of punishment or deprivation, because this involves an evaluation of his behavior from the standpoint of the "generalized other," or society. The psychopath will violate others' wishes and desires because he does not conceive of his own actions as inimical to their wants. He forms no deep attachments because he does not know how to identify himself with another or to share another's viewpoint. He lacks control because he cannot anticipate objections which others will make to his behavior.

³⁵ Hathaway has cited an interesting case in this regard. A female psychopath was unable to reply to a question about "humiliating experiences," because she did not understand what such experiences were. She knew what the word meant, but she was not able to tell whether she had ever had such an experience herself (Starke R. Hathaway, "The Personality Inventory as an Aid in the Diagnosis of the Psychopathic Inferior," *Journal of Consulting Psychology*, III (1939), 112-17).

³⁶ Bender's recent statement should be noted: "The primary defect (of psychopaths) is an inability to identify themselves in a relationship with other people, due to the fact that they experienced no continuous identification during the early infantile period from the first week through the period when language and social concepts, and psychosexual and personality development, were proceeding. Related to this lack of capacity to identify or to form an object-relationship is a lack of anxiety and an inability to feel guilt. It would thus appear that anxiety and guilt are not primarily instinctual qualities, but that they arise in reaction to threats to object relationships and identifications." (L. Bender, "Psychopathic Behavior Disorders in Children," in R. M. Lindner and R. V. Seliger (eds.), *Handbook of Correctional Psychology*, p. 374.)

If the psychopath is considered to be lacking in role-playing skills, and socially maladjusted because of this, then therapy should address itself to role-playing. The work of Moreno, and of others, on psychodrama has demonstrated one method of accomplishing this.³⁷ So far most of the work has been with neurotic persons, inhibited, fearful, and crippled by anxieties which interfere with a clear expression of their basic needs. For them the psychodrama provides an artificial spontaneity wherein unrestricted new approaches may be tested. In the psychopath there is little need for training in spontaneity; what is needed is a situation which will give him practice in disinterested analysis of self, from the viewpoint of others-in-general.³⁸

In younger psychopaths foster-home placement undoubtedly contributes somewhat to role-playing ability. Rogers mentions that in cases of behavior-problem children it is permissible to change from one foster-home to another.³⁹ He points out that such children often adjust fairly well when first transferred but that after a delay the delinquent behavior is again precipitated. It could be said that the child faces the new home with awakened interest and attention and that, as long as this attitude persists, practice in role-playing occurs—practice in foreseeing the effects of one's acts on others. Later, as the novelty of the new home wears off, the disability in role-playing, no longer counterbalanced by deliberate effort, again permits the appearance of unacceptable behavior. Assuming the validity of this admittedly speculative analysis, the prediction would be that more transfers, up to some reasonable limit, of course, would yield relatively more improvement in behavior than continuance in a constant regime.⁴⁰

³⁷ See J. L. Moreno, *Psychodrama* (New York: Beacon House, 1946).

³⁸ Sociodrama would presumably fulfill this need if the psychopath carried the part of judge of his own behavior. There is a strong possibility that the psychopath's shallowness of emotional response would preclude ego involvement and hence obstruct therapeutical progress; this is a technical problem, however, and is not a sufficient basis for the rejection of sociodrama as a plausible method. For a brief discussion of ego involvement see Gordon Allport, "The Psychology of Participation," *Psychological Review*, LIII (1945), 117-32.

³⁹ Carl R. Rogers, *The Clinical Treatment of the Problem Child* (Cambridge, Mass.: Riverside Press, 1939), chap. iv.

⁴⁰ That this is what actually does take place is indicated by S. D. Porteus, *The Practice of Clinical Psychology* (New York: American Book Co., 1941). He states: "Then when every thing seems to have reached a maximum of satisfactory adjustment, the social worker should remove the case to an-

The entering wedge may be driven home by the severity of the institutional discipline in incarcerated cases. The risks taken here are obviously great; the outcome may be favorable, nevertheless, as indicated by Whitaker's results.⁴¹ According to the role-playing hypothesis, such discipline eventually becomes so manifestly incongruous with the psychopath's own definition of the situation, and so detrimental to his personal preferences, that an immediate goal of escape or avoidance is set up whose attainment demands some consideration of the social repercussions of his own behavior.

Knight has found unretaliative permissiveness and indulgence to be highly efficacious in his treatment of irresponsible chronic alcoholics, a group including many psychopaths.⁴² If resolutions are made and broken, the therapist refrains from any rebuke or revengeful behavior. In some ways this attitude of the therapist sets up an artificial situation in which failures are not punished, thus giving the subject opportunity to try out new roles without fear of requital. Lippitt has stressed the necessity of establishing permissive "as if" situations where new social skills can be practiced without the fear that attends "playing for keeps."⁴³ Such practice in role-playing helps the subject to evaluate socially what he had previously done.

It must be remembered that the psychopath does not show intrapsychic conflict, or self-ambivalence, as does the neurotic, and does not ordinarily seek counseling or therapy. The narcissism and complete engulfment of the personality in psychopathy withdraws from the therapist a number of approaches open to him in treating neurotics and some types of psychotics. A neurosis, whatever may be its primary and secondary gains, is distinctly unpleasant (a compromise solution) in some respects, which may motivate the sufferer to seek treatment and welcome improvement.

The self-consistency theory of Lecky may also be mentioned.⁴⁴

other home" (p. 264). Porteus recommends a rotation of placements, for such cases.

⁴¹ C. A. Whitaker, "Ormsby Village: An Experiment with Forced Psychotherapy in the Rehabilitation of the Delinquent Adolescent," *Psychiatry*, IX (1946), 239-50.

⁴² Robert P. Knight, "The Psychodynamics of Chronic Alcoholism," *Journal of Nervous and Mental Diseases*, LXXXVI (1917), 538-48.

⁴³ Ronald Lippitt, "Techniques for Research in Group Living," *Journal of Social Issues*, II (1946), 55-61.

⁴⁴ Prescott Lecky, *Self-consistency: A Theory of Personality* (New York: Island Press, 1945).

NINETEEN

Individual and Social Origins of Neurosis *

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THE HISTORY of science is a history of erroneous statements. Yet these erroneous statements which mark the progress of thought have a particular quality: they are productive. And they are not just *errors* either; they are statements, the truth of which is veiled by misconceptions, is clothed in erroneous and inadequate concepts. They are rational visions which contain the seed of truth, which matures and blossoms in the continuous effort of mankind to arrive at objectively valid knowledge about man and nature. Many profound insights about man and society have first found expression in myths and fairy tales, others in metaphysical speculations, others in scientific assumptions which have proven to be incorrect after one or two generations.

It is not difficult to see why the evolution of human thought proceeds in this way. The aim of any thinking human being is to arrive at the *whole* truth, to understand the *totality* of phenomena which puzzle him. He has only *one* short life and must want to have a vision of the truth about the world in this short span of time. But he could only understand this totality if his life span were identical with that of the human race. It is only in the process of historical evolution that man develops techniques of observation, gains greater objectivity as an observer, collects new data which are necessary to know if one is to understand the *whole*. There is a gap, then, between what even the greatest genius can visualize as the truth, and the limitations of knowledge which depend on the accident of the historical phase he happens to live in. Since we cannot live in suspense, we try to fill out this gap with the material of knowledge at hand, even if this material is lacking in the validity which the essence of the vision may have.

Every discovery which has been made and will be made has a

* From *American Sociological Review*, 9 (August, 1944), 380-384. Reprinted by permission of the author and the publisher.

long history in which the truth contained in it finds a less and less veiled and distorted expression and approaches more and more adequate formulations. The development of scientific thought is not one in which old statements are discarded as false and replaced by new and correct ones; it is rather a process of continuous *reinterpretation* of older statements, by which their true kernel is freed from distorting elements. The great pioneers of thought, of whom Freud is one, express ideas which determine the progress of scientific thinking for centuries. Often the workers in the field orient themselves in one of two ways: they fail to differentiate between the essential and the accidental, and defend rigidly the whole system of the master, thus blocking the process of reinterpretation and clarification; or they make the same mistake of failing to differentiate between the essential and the accidental, and equally rigidly fight against the old theories and try to replace them by new ones of their own. In both the orthodox and the rebellious rigidity, the constructive evolution of the vision of the master is blocked. The real task, however, is to reinterpret, to sift out, to recognize that certain insights had to be phrased and understood in erroneous concepts because of the limitations of thought peculiar to the historical phase in which they were first formulated. We may feel then that we sometimes understand the author better than he understood himself, but that we are only capable of doing so by the guiding light of his original vision.

This general principle, that the way of scientific progress is *constructive reinterpretation of basic visions* rather than repeating or discarding them, certainly holds true of Freud's theoretical formulations. There is scarcely a discovery of Freud which does not contain fundamental truths and yet which does not lend itself to an organic development beyond the concepts in which it has been clothed.

A case in point is Freud's theory on the origin of neurosis. I think we still know little of what constitutes a neurosis and less what its origins are. Many physiological, anthropological and sociological data will have to be collected before we can hope to arrive at any conclusive answer. What I shall do is to use Freud's view on the origin of neurosis as an illustration of the general principle which I have discussed, that reinterpretation is the constructive method of scientific progress.

Freud states that the *Oedipus complex* is justifiably regarded as the kernel of neurosis. I believe that this statement is the most

fundamental one which can be made about the origin of neurosis, but I think it needs to be qualified and reinterpreted in a frame of reference different from the one Freud had in mind. What Freud meant in his statement was this: because of the sexual desire the little boy, let us say, has for his mother, he becomes the rival of his father, and the neurotic development consists in the failure to cope with the anxiety rooted in this rivalry in a satisfactory way. I believe that Freud touched upon the most elementary root of neurosis in pointing to the conflict between the child and parental authority and the failure of the child to solve this conflict satisfactorily. But I do not think that this conflict is brought about essentially by the sexual rivalry, but that it results from the child's reaction to the pressure of parental authority, the child's fear of it and submission to it. Before I go on elaborating this point, I should like to differentiate between two kinds of authority. One is *objective*, based on the competency of the person in authority to function properly with respect to the task of guidance he has to perform. This kind of authority may be called *rational* authority. In contrast to it is what may be called *irrational* authority, which is based on the power which the authority has over those subjected to it and on the fear and awe with which the latter reciprocate.

It happens that in most cultures human relationships are greatly determined by irrational authority. People function in our society as in most societies, on the record of history, by becoming adjusted to their social role at the price of giving up part of their own will, their originality and spontaneity. While every human being represents the whole of mankind with all its potentialities, any functioning society is and has to be primarily interested in its self-preservation. The particular ways in which a society functions are determined by a number of *objective* economic and political factors, which are given at any point of historical development. Societies have to operate within the possibilities and limitations of their particular historical situation. In order that any society may function well, its members must acquire the kind of character which makes them *want* to act in the way they *have* to act as members of the society or of a special class within it. They have to *desire* what objectively is *necessary* for them to do. *Outer force* is to be replaced by *inner compulsion*, and by the particular kind of human energy which is channeled into character traits. As long as mankind has not attained a state of organization in which the interest of the individual and that of society are identical, the

aims of society have to be attained at a greater or lesser expense of the freedom and spontaneity of the individual. This aim is performed by the process of child training and education. While education aims at the development of a child's potentialities, it has also the function of reducing his independence and freedom to the level necessary for the existence of that particular society. Although societies differ with regard to the extent to which the child must be impressed by irrational authority, it is always part of the function of child training to have this happen.

The child does not meet society directly at first; it meets it through the medium of his parents, who in their character structure and methods of education represent the social structure, who are the psychological agency of society, as it were. What, then, happens to the child in relationship to his parents? It meets through them the kind of authority which is prevailing in the particular society in which it lives, and this kind of authority tends to break his will, his spontaneity, his independence. But man is not born to be broken, so the child fights against the authority represented by his parents; he fights for his freedom not only *from* pressure but also for his freedom to be himself, a full-fledged human being, not an automaton. Some children are more successful than others; most of them are defeated to some extent in their fight for freedom. The ways in which this defeat is brought about are manifold, but whatever they are, the scars left from this defeat in the child's fight against irrational authority are to be found at the bottom of every neurosis. This scar is represented in a syndrome the most important features of which are: the weakening or paralysis of the person's originality and spontaneity; the weakening of the self and the substitution of a pseudo-self, in which the feeling of "I am" is dulled and replaced by the experience of self as the sum total of expectations others have about me; the substitution of autonomy by heteronomy; the fogginess, or, to use Dr. Sullivan's term, the parataxic quality of all interpersonal experiences.

My suggestion that the Oedipus complex be interpreted not as a result of the child's sexual rivalry with the parent of the same sex but as the child's fight with irrational authority represented by the parents does not imply, however, that the sexual factor does not play a significant role, but the emphasis is not on the incestuous wishes of the child and their necessarily tragic outcome, its original sin, but on the parents' prohibitive influence on the normal sexual activity of the child. The child's physical functions—first

those of defecation, then his sexual desires and activities—are weighed down by moral considerations. The child is made to feel guilty with regard to these functions, and since the sexual urge is present in every person from childhood on, it becomes a constant source of the feeling of guilt. What is the function of this feeling of guilt? It serves to break the child's will and to drive it into submission. The parents use it, although unintentionally, as a means to make the child submit. There is nothing more effective in breaking any person than to give him the conviction of wickedness. The more guilty one feels, the more easily one submits because the authority has proven its own power by its right to accuse. What appears as a feeling of guilt, then, is actually the fear of displeasing those of whom one is afraid. This feeling of guilt is the only one which most people experience as a moral problem, while the genuine moral problem, that of realizing one's potentialities, is lost from sight. Guilt is reduced to disobedience and is not felt as that which it is in a genuine moral sense, self-mutilation.

To sum up this point, it may be said that it is the defeat in the fight against authority which constitutes the kernel of the neurosis, and that not the incestuous wish of the child but the stigma connected with sex is one among the factors in breaking down his will. Freud painted a picture of the necessarily *tragic* outcome of a child's most fundamental wishes: his incestuous wishes are bound to fail and force the child into some sort of submission. Have we not reason to assume that this hypothesis expresses in a veiled way Freud's profound pessimism with regard to any basic improvement in man's fate and his belief in the indispensable nature of irrational authority? Yet this attitude is only one part of Freud. He is at the same time the man who said that "from the time of puberty onward the human individual must devote himself to the great task of freeing himself from the parents"; he is the man who devised a therapeutic method the aim of which is the independence and freedom of the individual.

However, defeat in the fight for freedom does not always lead to neurosis. As a matter of fact, if this were the case, we would have to consider the vast majority of people as neurotics. What then are the specific conditions which make for the neurotic outcome of this defeat? There are some conditions which I can only mention: for example, one child may be broken more thoroughly than others, and the conflict between his anxiety and his basic human desires may, therefore, be sharper and more unbearable; or

the child may have developed a sense of freedom and originality which is greater than that of the average person, and the defeat may thus be more unacceptable. But instead of enumerating other conditions which make for neurosis, I prefer to reverse the question and ask what the conditions are which are responsible for the fact that so many people do *not* become neurotic in spite of the failure in their personal fight for freedom. It seems to be useful at this point to differentiate between two concepts: that of defect and that of neurosis. If a person fails to attain freedom, spontaneity, a genuine experience of self, he may be considered to have a severe defect, provided we assume that freedom and spontaneity are the objective goals to be attained by every human being. If such a goal is not attained by the majority of members of any given society, we deal with the phenomenon of *socially patterned defect*. The individual shares it with many others; he is not aware of it as a defect, and his security is not threatened by the experience of being different, of being an outcast, as it were. What he may have lost in richness and in a genuine feeling of happiness is made up by the security of fitting in with the rest of mankind—as he knows them. As a matter of fact, his very defect may have been raised to a virtue by his culture and thus give him an enhanced feeling of achievement. An illustration is the feeling of guilt and anxiety which Calvin's doctrines aroused in men. It may be said that the person who is overwhelmed by a feeling of his own powerlessness and unworthiness, by the unceasing doubt of whether he is saved or condemned to eternal punishment, who is hardly capable of any genuine joy and has made himself into the cog of a machine which he has to serve, has a severe defect. Yet this very defect was culturally patterned; it was looked upon as particularly valuable, and the individual was thus protected from the neurosis which he would have acquired in a culture where the defect would give him a feeling of profound inadequacy and isolation.

Spinoza has formulated the problem of the socially patterned defect very clearly. He says: "Many people are seized by one and the same affect with great consistency. All his senses are so strongly affected by one object that he believes this object to be present even if it is not. If this happens while the person is awake, the person is believed to be insane. . . . But if the *greedy* person thinks only of money and possessions, the *ambitious* one only of fame, one does not think of them as being insane, but only as annoying; generally one has contempt for them. But *factually* greediness, ambition, and

so forth are forms of insanity, although usually one does not think of them as 'illness.' " These words were written a few hundred years ago; they still hold true, although the defect has been culturally patterned to *such* an extent now that it is not generally thought any more to be annoying or contemptuous. Today we come across a person and find that he acts and feels like an automaton; that he never experiences anything which is really his; that he experiences himself entirely as the person he thinks he is supposed to be; that smiles have replaced laughter, meaningless chatter replaced communicative speech; dulled despair has taken the place of genuine pain. Two statements can be made about this person. One is that he suffers from a defect of spontaneity and individuality which may seem incurable. At the same time it may be said that he does not differ essentially from thousands of others who are in the same position. With *most* of them the cultural pattern provided for the defect saves them from the outbreak of neurosis. With *some* the cultural pattern does not function, and the defect appears as a severe neurosis. The fact that in these cases the cultural pattern does not suffice to prevent the outbreak of a manifest neurosis is in most cases to be explained by the particular severity and structure of the individual conflicts. I shall not go into this any further. The point I want to stress is the necessity to proceed from the problem of the *origins of neurosis* to the problem of the *origins of the culturally patterned defect*; to the problem of the *pathology of normalcy*.

This aim implies that the psychoanalyst is not only concerned with the readjustment of the neurotic individual to his given society. His task must be also to recognize that the individual's ideal of normalcy may contradict the aim of the full realization of himself as a human being. It is the belief of the progressive forces in society that such a realization is possible, that the interest of society and of the individual need not be antagonistic forever. Psychoanalysis, if it does not lose sight of the human problem, has an important contribution to make in this direction. This contribution by which it transcends the field of a medical specialty was part of the vision which Freud had.

Factors in Mental Breakdown in Combat *

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I

MENTAL breakdown in combat is usually a transient situational personality disorder which has contributed heavily to the casualty rates of modern armies.¹ We shall use popular army jargon in referring to it as the NP (short for "neuropsychiatric") problem and in calling those affected by it NPs. The U. S. Army distinguishes the NP problem occurring in units stationed in the United States from that occurring in units stationed overseas but not in combat, and from that occurring in units in combat. Our study concerns only breakdown in combat,² and seeks to ascertain

* First printed in this volume. Unless otherwise indicated, the data for this article were collected in 1945, while the author was a member of the Research Branch, Information and Education Division, Mediterranean Theater of Operations, U. S. Army. Only a small portion of the data were analyzed at that time, and the present, more thorough, reanalysis has been sponsored by the Human Resources Research Office (HumRRO) of George Washington University. The author is grateful to M. Brewster Smith and Leland C. DeVinney for aid in planning the original study, to John L. Finan and Hobart Osburn of HumRRO for encouraging and criticizing this reanalysis, to Hans L. Zetterberg for his services as research assistant, to the following psychiatrists of the U. S. Fifth Army who collected information from their patients—Drs. Dreyer, Glass, Hanson, Holloman, Kaufman, Slutsky, Sobel, and Weinstein, and to Caroline B. Rose, Ephraim Rosen, and Shirley A. Star for criticism of the manuscript.

¹ In a small number of cases, breakdown in combat has signaled the onset of psychosis, temporary or permanent, rather than of mere personality disorder. An apparent breakdown can also be malingering or overfatigue. In calling breakdown in combat "neuropsychiatric" we are following psychiatric terminology during World War II; more recently psychiatrists have been inclined to call it "gross stress reaction" and to consider it a "personality disorder."

² The Research Branch at headquarters in the United States earlier conducted a study of garrison NPs. This study was under the general supervision of Samuel A. Stouffer and was headed by Shirley A. Star. The author drew upon his experiences in this study in planning the present one. See S. A. Stouffer *et al.*, *Studies in Social Psychology in World War II* (Princeton:

whether certain factors are associated with it.³

Clinically the NP case is difficult to describe, as he may present a variety of symptoms. In addition to the always-present fatigue and anxiety he may show visceral disturbances, tremor, muteness, depression, etc. The symptoms fluctuate in time, however; after a few days (during which the men are given medical and psychiatric attention) the symptoms tend to stabilize into more conventional psychiatric syndromes or disappear completely. Toward the end of World War II more than one-half of the NPs were returned to duty within a week after their breakdown. A smaller group were reclassified for duty in rear hospitals or were discharged from the Army.⁴

The data for this study were collected during the last months of World War II among white American combat infantrymen fighting against the Germans in Italy. Two groups of men will be reported on: (1) 328 NPs brought to division clearing stations⁵ who provided information within the first two or three days after their breakdown; these were a large proportion of all the infantrymen who broke down in combat during the period of the interviewing (December, 1944-March, 1945). (2) 1,754 combat enlisted men in infantry companies of the same divisions, providing information when their units were temporarily pulled out of combat in March, 1945; these constituted a representative cross section of American infantrymen then fighting in Italy. The two groups of men are directly comparable insofar as they are members of the same military units; for the purposes of the study the only possibly serious basis of noncomparability arises from the

Princeton University Press, 1950), vol. 2, chapter 9; and vol. 4, chapters 13 and 14.

³ There have been several other studies with this purpose reported in the journals of psychiatry. The most comprehensive of the relevant studies is that of William C. Menninger, *Psychiatry in a Troubled World* (New York: Macmillan, 1948), esp. pp. 134-152. Menninger summarizes all the earlier studies.

⁴ Malcolm J. Farrell and John W. Appel, "Current Trends in Military Psychotherapy," *American Journal of Psychiatry*, 101 (July, 1944), 12-19.

⁵ The division clearing stations were the front-most medical aid service stations next to the company-aid stations, which later were equipped to handle only minor wounds. Thus all neuropsychiatric casualties were sent to division clearing stations where the division psychiatrist and his assistants would treat them briefly and then either return them to combat or, in fewer cases, send them back to the next echelon of psychiatric treatment away from the front.

difference in the procedure by which information was collected from them. Both groups of men had recently come from combat; both were still within sound of shellfire although out of immediate danger. Both groups of men answered the same 115 questions.

Since the reader will have to judge whether answers provided by the two groups of men have approximately the same reliability, so that comparisons are possible, a fuller description will be given of the conditions of questionnaire administration. The techniques were developed during four years of war and had proven to be highly successful in eliciting frank and complete statements of personal fact and attitude.⁶ The questionnaire was developed from the hypotheses of the study, and the items were pretested and revised to make them simple and unambiguous. For group administration of the questionnaire to the cross section of combat enlisted men, arrangements were made, without advance notice, with local commanders by research officers carrying orders from Theater and Army Commanders. Approach to the men to be studied was made by a sociologist who was also an enlisted man (myself). The enlisted investigator explained the purpose of the survey, guaranteed anonymity, and urged frankness on the grounds that reports of the survey would be read by the highest Army officers—this being the one means by which enlisted men could communicate directly with the top command. The verbal assurance of anonymity was reinforced by the request that no names be placed on the questionnaire, by the group setting, and by the conspicuous stacking of questionnaires in piles as they were returned. The few semi-literates could request the investigator or their buddies to help them. Fewer than one-half of one per cent of the men selected to constitute this cross section failed to hand in a suitably completed questionnaire.

In order to get information from the NPs, arrangements were made with division psychiatrists and their enlisted assistants (who were psychologists), with a strong—and successful, it is believed—effort to have them understand and be sympathetic toward the study. Since NPs were brought in at all hours, and usually were in no condition to take the questionnaire at some previously fixed hour, the enlisted psychologist usually had to administer the questionnaires individually along with other routine psychological tests. The questionnaire was usually given on the day following the one

⁶ For a summary of many of the studies carried on in the Army using the techniques described in the text, see Stouffer *et al.*, *op. cit.*, 4 vols.

in which the NPs were brought to the station, and in any case before they knew what their disposition was to be. The enlisted psychologist assured the subjects of their anonymity and told them that their responses would in no way affect their treatment—in fact, would not even be seen by the psychiatrist or any other officer in the immediate command. He explained the purpose of the study, and said that the results were intended to help soldiers who had similar problems in the future. He then offered either to let the subject fill out the questionnaire himself or to read him the questions and write down the answers. About 10 per cent of the men brought to the clearing station were not given the questionnaire as they were judged to be in too disturbed a condition to answer the questions. About a half-dozen men each were excused when they said they did not want to answer or because they were illiterate. About a dozen other NPs were missed by the survey for such miscellaneous reasons as the regular enlisted psychologist being away during the entire period the NP was at the clearing station, the weather being too bad to permit writing (the stations sometimes consisted of tents), and so on. The sample of NPs is significantly biased, therefore, only in that the more serious cases (among them probably all the psychotics) are not included.

There are reasons for believing that the responses of the NPs and the cross section (hereinafter called "normals" or "control group") have the same degree of reliability, despite the difference in the manner of administering the questionnaire. First, it is our personal impression that both groups of men were frank and at least moderately motivated to give correct answers, and that the two techniques of questionnaire administration are equally successful in getting information. Second, there are some questions on which the two groups of men differed in the distribution of their responses and other questions on which they responded in somewhat the same way. Yet these questions can be matched in such a way so that there is no more reason to expect the NPs to falsify their answers to one set than to the other set. For example, NPs generally show up as more likely to be neurotically predisposed to breakdown than are normals, but not to the same extent on all items measuring psychoneurotic traits. Yet if some of them were lying, or felt especially pressured to give expected answers, with respect either to all of the questions or to some of them, they would show up as differently distributed, as compared to the normals, to approximately the same extent on all items measuring

psychoneurotic predisposition.⁷ The reason for this is that each man fills out his questionnaire independently, and if one man lies on some items, other men lie on other items, and the bias due to lying tends—if there is a large number of men—to create a consistent bias over all items. Actually, our data show that the discrepancies between NPs and normals turn up to a much greater extent on some items on which it might “pay” to lie than on others. A third reason for believing the answers of NPs and normals to have comparable reliability, also documented in the other report, is that differentials on attitude items hold up even when those who answer that they had pre-combat psychoneurotic complaints—the questions on which most falsification or pressure of the interview situation might be expected—are removed from the samples.

II

Our data can be used to test some current thinking about the NP problem. Clinical and military theorizing on the causation of combat NP breakdown has in general sought the explanation along three lines.

1. It has been hypothesized that the NP has, because of either heredity or early training, a predisposition for nervous breakdown. This explanation must, in its very nature, be considered as partial, because men who reach combat have been considerably screened for neuropsychiatric predisposition to breakdown during their prior Army experience. There is not only the brief screening by a psychiatrist at induction, but during the many months of training and adjustment to Army life the considerable number who cannot keep up are either separated from the Army or assigned to rear-echelon jobs. Those who are left to go into combat do not therefore include a large number who are ready to break down when they face relatively minor adversities. The explanation of NP in terms of a psychoneurotic predisposition parallels the explanation of most other nervous breakdowns.

2. Another explanation of the NP phenomenon stresses the strain and frustration of combat life. The cumulative experience of battle, the startling noises and blows from exploding shells, the witnessing of the wounded and the dead and of material destruction, the

⁷ Another report by me, based on the same data, shows the same pattern for attitude questions: “Conscious Reactions to Combat Associated with Neuropsychiatric Breakdown,” unpublished manuscript.

close calls of personal danger, the loss of sleep, the irregularity in satisfying the needs of the physical organism, etc.—all these things are believed to deteriorate any individual in due time, no matter how robust his mental health when he first enters combat. The saying that “every man has his breaking point” illustrates this type of explanation.

3. A final major area of explanation is found in the morale of the combat unit. A high NP rate—like a high rate of AWOL—is considered to be a function of low morale.

These three general hypotheses relating the incidence of NP cases to individual neurotic predisposition, situational strain, and group morale do not have to be formulated as mutually contradictory. Rather they should be considered as supplementary, each one contributing a share of the NP rate. They may be conceived of as independent in the sense that a negative change in any *one* of them may be expected to increase the NP rate; furthermore, negative changes in *all* of them simultaneously may have a cumulative effect in shooting up the NP rate. They should not be considered as all-inclusive; it is quite conceivable that other hypotheses could be advanced about other factors contributing to the NP rate. The factors considered are by no means new or original with this study. However, this study is one of the first in which these hypotheses can be statistically tested in a combat zone.

Let us first test the hypothesis that the NP rate is dependent on personality predispositions. The “weaker” personality structure of the NP is reflected in the number of psychoneurotic complaints he makes. The respondents were asked to check off their psychoneurotic complaints both before they entered combat and after they had started their combat duty. Table 1 provides a relevant summary of questions and answers for all the psychoneurotic complaints asked about, which are ones frequently referred to by psychiatrists.⁸

The conclusion from these distributions of answers is that the NPs claim that they had more psychoneurotic complaints before they entered combat duty, and that they have more psychoneurotic complaints while on combat duty, than do the “normals.” The differences are consistent for all questions asked and of high statistical significance for all but one of the items. Our minimum level of statistical significance here, as throughout this report, is a *t*-value of 95 per cent (calculated as the basis of totals that include the “no answer” cases, and by comparing the largest dif-

⁸ See, for example, Farrell and Appel, *op. cit.*

TABLE 1. PREVALENCE OF PSYCHONEUROTIC SYMPTOMS BEFORE AND DURING COMBAT AMONG NPS AND NORMALS

Questions	Responses	Percentages of	
		NP Group	Control Group
During your civilian and military life, but before you first went on active combat duty, did you ever have any fainting spells?	Yes, several times	8	6
	Yes, a few times	30	19
	Never had any	57	72
	No answer	5	3
		100	100
Since you have been on active combat duty, have you had any fainting spells?	Yes, several times	7	4
	Yes, a few times	31	17
	Never had any	56	75
	No answer	6	4
		100	100
During your civilian and military life, but before you first went on active combat duty, did your hands ever tremble enough to bother you?	Yes, often	14	10
	Yes, sometimes	41	29
	No, never	41	58
	No answer	4	3
		100	100
Since you have been on active combat duty, do your hands ever tremble enough to bother you?	Yes, often	31	16
	Yes, sometimes	45	48
	No, never	19	32
	No answer	5	4
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by having nightmares (dreams that frightened or upset you very much)?	Yes, many times	14	9
	Yes, a few times	47	39
	No, never	34	49
	No answer	5	3
		100	100
Since you have been on active combat duty, have you ever been bothered by having nightmares (dreams that frighten you or upset you very much)?	Yes, many times	22	15
	Yes, a few times	50	43
	No, never	22	38
	No answer	6	4
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by pressure or pain in the head?	Yes, often	17	12
	Yes, sometimes	39	35
	No, never	39	49
	No answer	5	4
		100	100

(continued)

TABLE 1 (continued)

Questions	Responses	Percentages of	
		NP Group	Control Group
Since you have been on active combat duty, have you ever been bothered by pressure or pains in the head?	Yes, often	26	16
	Yes, sometimes	44	43
	No, never	25	36
	No answer	5	5
		100	100
During your civilian and military life, but before you first went on active combat duty, how often were you bothered by having an upset stomach?	Nearly all the time	4	5
	Pretty often	28	21
	Never	52	56
	Not very often	11	14
	No answer	5	4
		100	100
Since you have been on active combat duty, how often have you been bothered by having an upset stomach? †	Nearly all the time	13	10
	Pretty often	39	38
	Not very often	38	41
	Never	5	7
	No answer	5	4
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by shortness of breath when you were not exercising or working hard?	Yes, often	20	17
	Yes, sometimes	36	34
	No, never	39	46
	No answer	5	3
		100	100
Since you have been on active combat duty, have you ever been bothered by shortness of breath when you were not exercising or working hard?	Yes, often	29	23
	Yes, sometimes	43	44
	No, never	22	28
	No answer	6	5
		100	100

* Braces indicate combinations made before significance of difference was calculated.

† Item for which difference between groups was not statistically significant.

ferences). Thus a psychoneurotic predisposition seems to be related to the incidence of combat NP, confirming what Star and others have found to be true of garrison NPs.⁹ However, it should be noted that the differences are ones of frequency only: consid-

⁹ In another article I show that combat NPs are considerably less likely than garrison NPs to have symptoms of psychoneurotic predisposition: "Neuropsychiatric Breakdown in the Garrison Army and in Combat" (unpublished manuscript).

erable numbers of men who hold up in combat have a few or many psychoneurotic complaints.

We now turn to the question of the relative contribution of a psychoneurotic predisposition in the total causal nexus of the NP phenomenon. It seems reasonable to assume that this factor would be most important for those who break down after a relatively short time in combat. The following figures indicate that there is a large group of early breakdowns:¹⁰

Time on Active Combat Duty	Percentages of	
	NP Group	Control Group
Less than 3 months	24	10
3-6 months	29	34
6-9 months	25	36
9 months or more	18	18
No answer	4	2
	100	100

It might be hypothesized that a psychoneurotic disposition plays a larger role in these early breakdowns than in later breakdowns.

To test this hypothesis let us compare those who break down before they have spent three months in combat ($N = 66$) with those who do not break down until they have been in combat longer than three months ($N = 262$). Table 2 gives the results of such a comparison.

It is evident that the 66 early breakdowns are a somewhat distinctive group marked by a higher rate of psychosomatic complaints. The differences are not quite statistically significant in the case of upset stomach and nightmares but their direction supports the conclusion.

In their high rate of psychoneurotic complaints the early breakdowns resemble the garrison NPs although they are not as extreme. The hypothesis might be advanced that the etiology of nervous breakdown in garrison life and of breakdown in early weeks of combat is roughly similar: Both have a predisposition to break down when faced with difficult, new situations.

¹⁰ The only other background factor measured which significantly distinguishes the NPs from the normals is age. Of the NPs, 12 per cent are above 35 years of age, as compared to 4 per cent of the control group. There is only a slight difference between the two groups in terms of education, marital status, length of time in the Army and overseas, and Army rank.

TABLE 2. PREVALENCE OF PRE-COMBAT PSYCHO-NEUROTIC SYMPTOMS AMONG TWO GROUPS OF NPS

Questions	Responses	Percentages of	
		NPs after Less than Three Months in Combat	NPs with More than Three Months in Combat
During your civilian and military life, but before you first went on active combat duty, did you ever have any fainting spells?	Yes, several times	15	5
	Yes, a few times	29	31
	Never had any	55	61
	No answer	1	3
		100	100
During your civilian and military life, but before you first went on active combat duty, did your hands ever tremble enough to bother you?	Yes, often	• { 17	13
	Yes, sometimes	• { 50	38
	No, never	32	47
	No answer	1	2
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by having nightmares (dreams that frightened or upset you very much)? †	Yes, many times	• { 15	11
	Yes, a few times	• { 52	46
	No, never	30	41
	No answer	3	2
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by pressure or pains in the head?	Yes, often	• { 23	15
	Yes, sometimes	• { 38	34
	No, never	38	47
	No answer	1	4
		100	100
During your civilian and military life, but before you first went on active combat duty, how often were you bothered by having an upset stomach? †	Nearly all the time	• { 9	3
	Pretty often	• { 30	29
	Not very often	44	56
	Never	15	9
	No answer	2	3
		100	100

Questions	Responses	Percentages of	
		NPs after Less than Three Months in Combat	NPs with More than Three Months in Combat
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by shortness of breath when you were not exercising or working hard?	Yes, often	30	22
	Yes, sometimes	31	31
	No, never	36	44
	No answer	3	3
		100	100

* Braces indicate combinations made before significance of difference was calculated.

† Items for which difference between groups was not statistically significant.

Psychoneurotic predisposition to combat breakdown is indicated not only by psychoneurotic complaints but also by certain psychosocial characteristics. Significantly smaller proportions of NPs than of normals like to be with other people, said that they dated in civilian life as often as other fellows they knew, reported that they liked to take part in sports when they were children, reported that they liked to fight and that they got into fights when they were children, said that they were considered healthy as children. Considerably larger percentages of NPs than of normals reported that their father or mother had had a nervous breakdown and reported that they themselves had been treated by a doctor for "nervousness" before going into the Army. Percentage distributions on these characteristics are presented in Table 3. It is to be noted that the percentage differences are not large, even though statistically significant. There are certain childhood experiences, on the other hand, for which there are no percentage differences between NPs and normals. These include: playing hookey from school, stuttering or stammering, judgment as to whether punishment by parents was deserved or not, estimate of whether or not other people like one, whether parents lived together, and judgment as to how well parents got along.

A final set of items that can be considered relevant to neurotic predisposition are childhood fears. NPs are somewhat more likely than normals to report that they were afraid, as children, of certain of the things inquired about, but not about other things. In no

TABLE 3. DIFFERENCES IN PSYCHOSOCIAL CHARACTERISTICS BETWEEN NPS AND NORMALS

Questions	Responses	Percentages of	
		NP Group	Control Group
On the whole, before you came into the Army, did you usually like to be by yourself or to be with other people?	Usually liked to be by myself	27	20
	Usually liked to be with other people	61	72
	Undecided	9	4
	No answer	3	4
		100	100
Did you usually have dates with girls more often or less often than most other fellows of about your age that you know?	More often than most other fellows		
	I know	6	11
	About the same as most other fellows		
	I know	58	60
	Not as often as most other fellows I know	31	25
	No answer	5	4
		100	100
When you were a boy, how much did you like to take part in sports?	Very much	46	53
	Pretty much	20	25
	Not so much	26	16
	Not at all	4	2
	No answer	4	4
		100	100
When you were a kid, how did you feel about fighting?	Really liked fighting	10	10
	Didn't particularly like or dislike it	30	38
	Didn't like fighting at all	54	47
	No answer	6	5
		100	100
How often did you get into fights when you were a kid?	Very often	5	8
	Pretty often	10	14
	Not so often	42	43
	Almost never	38	31
	No answer	5	4
		100	100

Questions	Responses	Percentages of	
		NP Group	Control Group
Were you considered a healthy child or a rather sickly one?	Very healthy as a child	24	42
	Fairly healthy as a child	46	41
	Rather sickly as a child	19	10
	Very sickly as a child	6	2
	No answer	5	5
		<u>100</u>	<u>100</u>
So far as you know, has anyone in your family ever had a nervous breakdown?	No	24	45
	Yes, father or mother	35	26
	Yes, brother or sister	8	6
	Yes, wife or relative not specified	3	3
	Yes, other specified relative	2	1
	Don't know	24	15
	No answer	4	4
		<u>100</u>	<u>100</u>
Before you came into the Army, were you ever treated by a doctor for nervousness?	Yes	26	14
	No	69	82
	No answer	5	4
		<u>100</u>	<u>100</u>

case were a larger proportion of normals than of NPs afraid of the things inquired about. As Table 4 shows, a significantly higher proportion of NPs report themselves as having been afraid of being on high places, of thunderstorms, of getting bawled out, of being laughed at by other boys. There is no difference in the proportions of NPs and normals in reported fear of strangers, and only slight—not statistically significant—differences in reported fear of large animals and of death. The large proportions of “no answers” to these questions—probably because of the latter’s cramped position in, and their placement toward the end of, the questionnaire—possibly reduces the reliability of the conclusions based on Table 4.

TABLE 4. PREVALENCE OF CHILDHOOD FEARS
AMONG NPS AND NORMALS

Question: "Below is a list of things commonly feared by children. Some of them are important in medical histories, but nothing is known about how often the average person has been afraid of these things. Check *one* answer for *each* thing listed—to show how much you yourself were afraid of it when you were a child.

Childhood Fears	Very Much Afraid		A Little Afraid		Not Afraid		Not Answering	
	Among NPs, %	Among Normals, %	Among NPs, %	Among Normals, %	Among NPs, %	Among Normals, %	Among NPs, %	Among Normals, %
Being left alone	25	19	36	38	23	26	16	17
Being on high places	33	23	29	30	20	28	18	19
Thunderstorms	26	15	30	27	27	37	17	21
Strangers	6	5	24	24	47	47	23	24
Getting bawled out	24	16	36	37	19	27	20	20
Large animals	13	9	27	29	35	37	25	25
Being laughed at by other boys	17	10	25	25	34	41	24	24
Thoughts of death	34	30	28	32	19	19	19	19

III

In this section let us turn to the evidence relating the incidence of NP to situational factors. First it might be noted that there is some relationship between NP breakdown and the experience of being knocked out by an explosion. Of our NPs, 40 per cent report that they have at some time been knocked out in action by an explosion, as compared to 27 per cent of the control group. This effect of exposure to explosion is maintained when time in combat is controlled. Among those with less than three months of combat experience, the figures are 36 per cent and 13 per cent, for NPs and normals, respectively; for those with more than three months of combat the difference is smaller—44 per cent as compared to 38 per cent—but still statistically significant because of the large size of the groups. This finding does not necessarily mean that a sizable proportion of the NPs experienced the *onset* of their breakdown during an explosion; in some cases it means simply that they have been subjected to more drastic combat conditions before the onset of their breakdown.

Situational strain is also evidenced in the larger number reporting insufficiency of food and sleep among NPs than among normals during the last active combat duty, although much of this is probably self-induced by psychoneurotic predisposition rather than by the objective situation. Comparing NPs and normals on the reasons given for not getting sufficient food, 32 per cent of the NPs as compared to 10 per cent of the normals said they did not feel like eating, whereas 14 per cent of the NPs as compared to 22 per cent of the normals said the food was not available, and 7 per cent of the NPs as compared to 30 per cent of the normals said they did not like the food available. The proportions reporting an average of less than 4 hours of sleep during each 24 hours of last active combat duty was 48 per cent among NPs and 31 per cent among normals. Other questions designed to measure situational strain fail to produce any differences. Thus the difference in the proportion of wounded men between the NP group and the control group is negligible—44 per cent and 43 per cent, respectively. Also, to the extent that awards of decorations tell anything about the risk and performance of combat duty there is no difference between NPs and normals. On the assumption that the initial experience of combat was important, they were asked what kind of

action they saw when they first came to the front, but the answers do not reveal any real difference between NPs and normals. In conclusion, then, when all NPs are compared to the total control group no clear-cut factor of situational strain other than an incapacitating experience with exposure to explosion seems to differentiate the groups.

However, on the same questions the cases of early breakdown in combat answer as a distinctive group. We have already seen how this is true on the question about being knocked out in action by an explosion. If we further compare our 66 NPs who broke down before completing three months of combat with a control group of 186 normals who also spent less than three months in combat we find that 49 per cent of these early NPs have been wounded in action as compared to 20 per cent of the control group, 32 per cent have been cited in orders or received Army decorations as compared to 12 per cent of the control group.¹¹ The kind of action these early NPs encountered during their first experience at the front also differs from that of the normals, as shown by the following figures for men with less than three months of active combat duty:

Kind of Action First Encountered	Percentage of	
	NP Group	Control Group
Holding action during a quiet period	30	55
Defensive action during an enemy attack	12	5
Attack against light enemy resistance	29	14
Attack against heavy enemy resistance	26	20
Some other sort	1	2
No answer	2	4
	100	100

It is apparent that the first combat experience of the NPs is harder than the corresponding experience for the control group, at least in terms of the soldiers' own judgments.

Certain situational strains which, contrary to expectation, were experienced just as frequently by normals as by NPs are: (1) seeing a close friend killed or wounded in action, (2) seeing a man's

¹¹ The main source of difference between NPs and normals in decorations received was the larger proportion of the former receiving Purple Hearts for having been wounded in action. But 3.0 per cent of the NPs, as compared to 0.5 per cent of the normals, reported having received the Bronze Star or the Silver Star—a difference not large enough to be statistically significant.

nerves "crack up" at the front. A significantly larger proportion of normals than of NPs report that they have been bombed or strafed by our own planes, or fired on by our own artillery. Because NPs have not experienced more of these trauma than normals does not mean that they play no role in the onset of their breakdown; they might, for example, serve as focusing points for the anxieties of NPs. But they do not seem to act as "sufficient cause" of neuropsychiatric breakdown.

It thus appears that factors of situational strain are most conspicuously related to early breakdown in combat.¹² Those who break down later might to a slightly higher extent have been exposed to an incapacitating explosion but this experience also seems to be most closely related to early breakdown. The early NPs were more likely to perceive their first combat as difficult than were the control group. Half of the early breakdown cases had been physically wounded, as compared to only a fifth of the control group—one of the largest single differences found in this study.

IV

The sociologically most relevant problem in the NP complex centers around the relation between group morale and NP rate. Morale is an inclusive term covering many phenomena of adequate group functioning. For research purposes the term has to be broken up into several components, and there are no a priori reasons to assume that these components are interrelated. The many components of military morale can probably best be defined through enumeration: Identification with the war effort, confidence in training, confidence in equipment, hatred of the enemy, confidence in officers, acceptance of the military reward system, confidence in rear echelons, a belief that the unit is well-managed, a feeling that headquarters understands one's problems, and many other factors make up military morale.

All of these components of Army morale are attitudes involving a judgment of some aspect of Army life. Now it is important to note that there are great difficulties in finding objective criteria for making these judgments. It is virtually impossible for a front-line soldier to establish strict standards for answering questions

¹² S. A. Star—using these and other data—demonstrates that combat increased psychoneurotic symptoms. See Strouffer *et al.*, *op cit.*, vol. II., pp. 445-455.

such as: how much is a fair effort of a rear echelon (given his particular situation), how fair are officers in combat conditions (given their situation about which the enlisted men may know only a fraction), what is good performance of a company (given its situation and resources), how fair is the reward of a Bronze Star to one soldier but not to another? Yet soldiers express attitudes on these matters, and, what is more remarkable, they often agree in their individually expressed opinions on these matters.

Lacking objective measuring rods for judging a phenomenon, different persons in a group may achieve agreement through communication with each other. On the other hand, it is entirely possible that different groups passing judgment on the same phenomena may end up with very different results. Thus, one effect of this process is that between-group variations in these attitudinal judgments are larger than within-group variations of the same attitude.¹³ Good morale might be said to prevail in units agreeing on favorable and generous attitudes toward the Army when lacking standardized, objective criteria to aid the judgment. Bad morale, on the other hand, is found in units in which the lack of standardized, objective criteria to aid judgment permits the men to agree upon critical and unfavorable attitudes toward the Army. We shall now test the proposition that group morale conceived in this way is related to the occurrence of NP casualties.

The units to be investigated are battalions. A battalion is not an ideal unit for our purpose since it is so large (generally containing about a thousand enlisted men) that subgroups of the battalion may agree upon different attitudes and that therefore the within-battalion variations in attitudes may be large. However, since our representative sample of Fifth Army combat men did not yield subsamples of sufficient size for statistical analysis from units smaller than battalions (i.e. platoons or companies), we used battalions as units. In veteran combat outfits such as ours battalions tend to be real sociological groups. Our research design called for two battalions belonging to the same regiment, one of which showed high morale and one of which showed low morale, and each of which had at least 100 studied cases. Of the seven pairs of battalions (each pair being from the same regiment) in our sample

¹³ This truistic statement has received empirical verification in Muzafer Sherif, *The Psychology of Social Norms* (New York: Harper, 1936), and more recently in Leon Festinger *et al.*, *Theory and Experiment in Social Communication* (Ann Arbor: Research Center for Group Dynamics, 1950).

the pair with the largest number of differences in 25 attitudes toward Army life was chosen for study. In a relative sense, then, one of the pair had high morale and the other low morale. The two battalions will hereafter be respectively designated as Battalion Hi and Battalion Lo. The size of the sample from Hi is 120 cases and from Lo 121 cases.

The fact that Battalion Hi and Battalion Lo belong to the same regiment serves as a controlling factor—it means that they have been in combat equally long,¹⁴ that they have the same higher command, that they have about the same training and equipment, that they serve in neighboring areas of the front, etc. However, before showing how these battalions differ in morale and NP rate it is worth investigating the extent to which they are equal in regard to the two factors that we have learned affect the NP rate—that is, psychoneurotic predisposition and situational strain. Table 5 indicates the distribution of psychoneurotic complaints in the two battalions before they entered combat. Only normal soldiers (no NPs) are included in these and the following breakdowns.

While the differences show no consistent trend some of the comparisons give the impression that Battalion Hi is basically mentally healthier. However, in no case are differences large enough to meet a two-tailed test of statistical significance at a level appropriate for such a large number of comparisons. Thus we may regard the two battalions as roughly matched in regard to the presence of pre-combat psychoneurotic characteristics.

The battalions are better matched in regard to experience of situational strains. In respect to the proportion of men knocked out of action by an explosion—previously found to be highly related to occurrence of NP casualties—40 per cent in Battalion Lo have had this experience, and in Battalion Hi 41 per cent have had it. The difference is obviously insignificant. In respect to the judgment of the number of battle casualties, Battalion Lo has suffered 24 casualties per company per month of combat, and the corresponding figure for Battalion Hi is 25 casualties.¹⁵ Thus the

¹⁴ That is, as military units they have been in combat equally long; not all the men in them have been in combat equally long, obviously, because of the American military practice of keeping units "up to strength" with replacements.

¹⁵ The figures are based on answers to questions asking information about time in present company, time of combat duty, and number of men in the company who have become battle casualties since the respondent joined the company. Company records are not available.

TABLE 5. PREVALENCE OF PRE-COMBAT PSYCHONEUROTIC SYMPTOMS IN TWO BATTALIONS

Question	Responses	Percentages of	
		Battalion Lo	Battalion Hi
During your civilian and military life, but before you first went on active combat duty, did you ever have any fainting spells?	Yes, several times	7	9
	Yes, a few times	23	22
	Never had any	68	67
	No answer	2	2
		100	100
During your civilian and military life, but before you first went on active combat duty, did your hands ever tremble enough to bother you?	Yes, often	10	9
	Yes, sometimes	38	28
	No, never	51	61
	No answer	1	2
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by having nightmares (dreams that frightened or upset you very much)?	Yes, many times	13	6
	Yes, a few times	39	48
	No, never	46	43
	No answer	2	3
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by pressure or pain in the head?	Yes, often	14	16
	Yes, sometimes	31	33
	No, never	54	48
	No answer	1	3
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by having an upset stomach?	Nearly all the time	6	5
	Pretty often	21	24
	Not very often	60	52
	Never	12	15
	No answer	1	4
		100	100
During your civilian and military life, but before you first went on active combat duty, were you ever bothered by shortness of breath when you were not exercising or working hard?	Yes, often	19	14
	Yes, sometimes	39	44
	No, never	40	38
	No answer	2	4
		100	100

casualty rate in the two battalions is roughly equal, at least in terms of the men's reported experience.

In certain other aspects, less relevant in terms of our theory, the battalions are less well matched. The average education is slightly higher in Battalion Lo. The proportion of married men is higher in Battalion Lo. Length of time spent in the Army is equal for the two battalions, as is length of combat experience. However, the men in Battalion Hi spent less time in their present outfits before they saw action. These differences may be regarded either as among the factors contributing to the difference in morale between the two battalions or as irrelevant in the etiology of NP. In either case there is no need to hold them constant.

Having held constant the other two factors affecting the NP rate—psychoneurotic predisposition and situational strain—as well as certain organizational aspects of Army life, we are now in a position to test an hypothesis concerning the relationship between morale and the occurrence of NP casualties. It is to be recalled that no clear-cut difference was found between the two battalions in the proportion of men remembering having had psychoneurotic symptoms prior to the beginning of combat duty. Table 6 shows, however, that the proportion of men reporting symptoms *after* the beginning of combat duty is higher in Battalion Lo. The differences are consistent and all but the last two are of a magnitude to meet a test of statistical significance (at the five-per-cent level).

This relationship is reflected in the NP rate of the two battalions. The ratio of total NP rates between Battalion Lo and Battalion Hi during the period of interviewing is 5 to 3. If the rates are based only on those who were unable to return to combat the relation is 2 to 1. Thus there is evidence that the occurrence of NP casualties, apart from being affected by psychoneurotic predisposition and situational strain, is related to group morale.

V

In summary, the following points may be made.

1. Those who suffer neuropsychiatric breakdown in garrison life or in their first few weeks of combat are more likely than those who do not have breakdowns to have a pre-Army history of neurotic disturbance. They are also more likely to perceive themselves as having weak constitutions and other psychosocial disturbances.

TABLE 6. PREVALENCE OF PSYCHONEUROTIC SYMPTOMS DURING COMBAT IN TWO BATTALIONS

Question	Responses	Percentages of	
		Battalion Lo	Battalion Hi
Since you have been on active combat duty, have you had any fainting spells?	Yes, several times	7	6
	Yes, a few times	31	16
	Never had any	61	74
	No answer	1	4
		100	100
Since you have been on active combat duty, do your hands ever tremble enough to bother you?	Yes, often	23	11
	Yes, sometimes	53	54
	No, never	22	32
	No answer	2	3
		100	100
Since you have been on active combat duty, have you ever been bothered by having nightmares (dreams that frightened or upset you very much)?	Yes, many times	25	13
	Yes, sometimes	46	52
	No, never	27	32
	No answer	2	3
		100	100
Since you have been on active combat duty, have you ever been bothered by pressure or pains in the head?	Yes, often	29	13
	Yes, sometimes	35	50
	No, never	34	33
	No answer	2	4
		100	100
Since you have been on active combat duty, how often have you been bothered by having an upset stomach?	Nearly all the time	11	6
	Pretty often	46	43
	Not very often	34	40
	Never	8	7
	No answer	1	4
		100	100
Since you have been on active combat duty, have you ever been bothered by shortness of breath when you were not exercising or working very hard?	Yes, often	27	27
	Yes, sometimes	50	45
	No, never	21	23
	No answer	2	5
		100	100

2. Variations in the situational strain of combat are likely to affect the occurrence of NP breakdown, especially during the first three months of combat assignment. Situational strains in the form of exposure to heavy explosion or experience of being wounded relate rather sharply to occurrence of NP casualties.

3. Army units develop agreements in attitudes concerning many aspects of Army life without having objective bases for their judgments. High morale units are defined as those in which the members agree on judgments favorable and generous toward the Army. One studied unit of this kind showed a lower rate of psychoneurotic complaints and NP casualties than a reasonably well-matched unit of lower morale.

SECTION V

The Social Psychology of Personality Organization and Disorganization

TWENTY-ONE

A Socio-Psychiatric Approach to Personality Organization *

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THERE are many approaches to personality. They have varied from the elementaristic to the holistic, from the peripheralistic to the centralistic, or from the psychoanalytic, personalistic to the topological.¹ This paper, however, is an outgrowth not so much from a logical need to reconcile those opposing theories of personality as from a practical necessity to account for the behavior phenomena that the writer has encountered from day to day as a lay analyst and a sociologist for a number of years and in different cultural settings.² It is hoped, though, that what is presented in

* Paper read at the annual meeting of the American Sociological Society held in Chicago, September 5-7, 1951. Reprinted from *American Sociological Review*, 17 (February, 1952), 44-49. Reprinted by permission of the author and the publisher.

¹ Angyal, A., *Foundations of a Science of Personality*, 1941; Maslow, A. H., "Dynamics of Personality Organization," *Psychological Review*, 50 (1943): 514-539; Rosenzweig, S., "Converging Approaches to Personality," *Psychological Review*, 51 (1944): 248-275.

² The writer started his work as a lay analyst and sociologist at the Peiping Union Medical College in China in 1935 and worked among American

the following may be of some use to those better qualified to discuss strictly theoretical problems.

The approaches employed and found most useful in the writer's work, to use the words of Edward Sapir, may be simply called the sociological and the psychiatric.³ The sociological approach looks upon the human individual not only as a biological organism but always as a member of society and a carrier of culture and his behavior at any given point of time as a function of the interaction between him and the on-going socio-cultural situation as he defines it.⁴ The psychiatric approach, on the other hand, tends to emphasize the unique and the relatively enduring systems of reactivity on the part of the individual, especially those integrative and adjustive processes that are characterized by low degrees of personal awareness. A combination of these views, or what is here called the socio-psychiatric approach, therefore, will incline one to think of man not only as a psychophysical organization, but one that "embodies countless cultural patterns in a unique configuration":⁵ one that is characterized by "relatively enduring life processes,"⁶ accompanied by different degrees of awareness and functioning almost always in a socio-cultural context, actual or imaginary; and one that responds to any given situation always in terms of its meaning to itself. This approach is increasingly recognized by practically all serious students of personality, although it has been known by different names in different disciplines.⁷

Negroes at Fisk University from 1939 to 1942. Since 1943 he has been associated with the Department of Psychiatry, and since 1947 also with the Department of Psychology, Duke University.

³ Sapir, E., "Personality," *Encyclopedia of the Social Sciences*, 12 (1934); 85-88.

⁴ Thomas, W. I., *The Polish Peasant in Europe and America* (1927), pp. 1847-1849.

⁵ Sapir, *op. cit.*

⁶ Sullivan, H. S., "Multidiscipline Coordination of Interpersonal Data," *Culture and Personality*, edited by S. S. Sargent and M. W. Smith (1949), pp. 175-194.

⁷ This approach is called the interpersonal theory by Harry S. Sullivan in *Conceptions of Modern Psychiatry*, the field theory by Gardner Murphy in *Personality: A Bio-Social Interpretation*, and the personal frame of reference by Snygg and Combs in *Individual Behavior*.

SOME EMPIRICAL CLINICAL OBSERVATIONS

A clinician using the socio-psychiatric approach and working intensively with patients for a long period of time can hardly escape the following empirical observations: (1) Each patient seeking treatment seems to be perennially preoccupied with what kind of person he is, that is, the self as an object. It also seems that each patient has a preferred self-picture that he has had difficulty in realizing, and because of this he is now beset by anxiety, guilt or aggression, or by half-hearted or unsuccessful attempts to live up to such a self-picture that have resulted in psychiatric symptoms.⁸ (2) What has prevented the patient from realizing his preferred self-picture seems to consist of impulses that are accompanied by different degrees of personal awareness; some of these impulses are readily accessible to consciousness while others are not accessible. These conflicting impulses seem to function at the same time in situations emotionally significant to the individual. (3) Not only those life processes of which the individual is fully aware but also those characterized by low degrees of awareness tend to cluster. Such clusters have been variably represented as complexes, traits, trends, themas, or just attitudes.⁹ In fact, such clusters of behavior patterns seem to be organized around unitary, though often conflicting, roles or self-concepts that the individual has attempted to play or realize in the socio-cultural situations confronting him. (4) All roles or self-concepts seem to have definite socio-cultural referent situations, or consist of what Sullivan called the "me-you patterns."¹⁰ This is as true of the roles or self-concepts acquired in an individual's primary group environment as it is of those acquired later through membership in the secondary groups. (5) The conflicts of neurotic patients seem to be fundamentally conflicts of roles or self-concepts, having their origins in the conflicting socio-cultural environments with which the individual has

⁸ Cf. Murphy, *Personality*, p. 561.

⁹ These clusters of impulses have been called complexes by Freud (*General Introduction to Psychoanalysis*), traits by Allport (*Personality: A Psychological Interpretation*), thema by Murray (*Explorations in Personality*), trends by Horney (*The Neurotic Personality of Our Time*) and attitudes by many sociologists and psychologists.

¹⁰ Sullivan, H. S. "Psychiatry: An Introduction to the Study of Interpersonal Relations," *A Study of Interpersonal Relations* edited by P. Mullahy (1949), pp. 98-121.

been identified in the course of his development. (6) In spite of these conflicts, however, the human individual, it seems, never ceases to strive for a consistent self-picture, one that he considers as appropriate to his present-day socio-cultural environment. In fact, the so-called neurotic symptoms can be shown, in many instances, to be just such conscious or unconscious attempts at self-consistency.¹¹ (7) A change in behavior is often found to follow a change in self-concept;¹² in fact, it seldom occurs otherwise. Very frequently when a patient's self-esteem increases, his previous complaints imperceptibly lose their importance. And (8) changes in self-concepts most frequently result from changes in self-other relations, the "other" being either the therapist in the therapeutic situation or the patient's associates in real life situations. This fact has been emphasized in different ways by practically all schools of psychotherapy.¹³

On the basis of such observable facts as mentioned above, certain hypotheses regarding personality organization have appeared to the writer as worthy of consideration. They will be presented first in a summary fashion. Then a discussion will follow.

SOME HYPOTHESES REGARDING PERSONALITY ORGANIZATION

1. Human personality, on its higher levels of integration, may be thought of as an organization of selves or self-concepts.¹⁴
2. Each of the selves in a personality organization has a definite socio-cultural referent situation, or has resulted from the interaction between the individual and a specific socio-cultural environment.
3. The organization of these selves appears to be hierarchical. The self that is acquired in the first or family group environment seems to be the most basic, while others acquired later in the secondary group environments vary in importance to the individ-

¹¹ Cf. Lecky, P., *Self Consistency: A Theory of Personality*, 1945.

¹² Rogers, C. R., "The Significance of the Self Regarding Attitudes and Perceptions," *Feelings and Emotions*, edited by M. L. Reymert (1950), pp. 374-382.

¹³ Alexander, F., French, T. M., et al., *Psychoanalytic Therapy*, 1946; Fromm-Reichmann, F., *The Principles of Intensive Psychotherapy*, 1950; Rogers, C. R., *Client-Centered Therapy*, 1951.

¹⁴ Cf. Allport, *op. cit.*, pp. 139-141.

ual's self-picture of the moment, depending on the situation he is confronted by.¹⁵

4. The self that is acquired in the primary group environment may be called the primary self, while the selves acquired in the secondary group environments are the secondary selves. The primary self tends to create life goals and set in motion certain basic self-defending and self-enhancing mechanisms or patterns that may persist in some form throughout the individual's life and condition his adaptation to later socio-cultural situations.

5. The primary self is either favorable or unfavorable, acceptable or unacceptable, to the person. The former tends to facilitate personality growth and adaptation to changing situations, while the latter tends to do the opposite.¹⁶ Both kinds of processes may operate with or without the individual's awareness.

6. The relationship between the primary self and the secondary selves seems to be a very intimate one. The primary self almost invariably serves as a selector in the individual's later dealings with the secondary group situations and tends to incorporate or utilize the latter for the solution of its unresolved problems, with or without awareness on the part of the individual. On the other hand, the secondary self at any given point of time, especially if it is very much consciously preferred, tends to assert an inhibiting or integrative influence over the selves acquired earlier in the individual's development.

7. The degree of integration of the primary self and the secondary selves, or the degree of organization in a personality, seems to depend, to a very large extent, on the degree of continuity or congruity between an individual's primary or earlier socio-cultural environments and his secondary or later socio-cultural environments.¹⁷

8. There seems to be a natural tendency on the part of the human organism toward consistency or integration or to act as a whole. This tendency often necessitates the exclusion or dissociation of those impulses and behavior patterns from personal awareness that are not consistent with the individual's preferred self-

¹⁵ Cf. Angyal, *op. cit.*, on the vertical dimension of personality organization, pp. 264ff.

¹⁶ Cf. Allen, F., *Psychotherapy with Children* (1942), pp. 24-29.

¹⁷ Cf. Benedict, R., "Continuities and Discontinuities in Cultural Conditioning," *Personality in Nature, Society and Culture*, edited by C. Kluckhohn and H. A. Murray (1948), pp. 414ff.

picture in a given socio-cultural situation, thus resulting, in certain cases, in the kind of anxiety and defense mechanisms that eventually lead to neurotic symptoms.¹⁸

9. The behavior of a human individual in any given socio-cultural situation and at any given point of time may be thought of as a function of the interaction between his personality organization as conceptualized above and the situation as it appears to him.¹⁹

10. The organism is at all times the core of a personality organization. An individual's efforts to integrate his various self-concepts together with their respective behavior patterns may be thought of as manifestations of the organisms' basic homeostatic processes at the self-other and self-culture levels. In other words, the human individual seems to act at all times as a bio-social whole.²⁰

DISCUSSION

The idea that the behavior of a human individual is usually organized around his conception of himself and that a human personality consists of a hierarchy of self-concepts, of course, is not new.²¹ Ever since the fad of radical behaviorism has subsided, the concept of self has been utilized by an increasing number of academic psychologists as well as clinicians.²² While some of them, like Allport, tend to stress personality as an intrapsychic organization, others, like Murphy, place great emphasis on the relationship between the selves and the environment. With respect to the latter point of view, of course, the contributions of the sociologists have been the most outstanding and the most consistent, though little recognized in current psychological and psychiatric literature. According to Sorokin, for example, "the structure of the individual's egos may be considered as a microcosm corresponding to the social macrocosm of the groups to which the individual belongs." His thesis, very similar to the writer's, is that "the individual has not one empirical soul, or self, or ego, but several: first, biological; and second, social egos. The individual has as many different social

¹⁸ May, R., *The Meaning of Anxiety* (1950), pp. 343ff.

¹⁹ Cf. Lewin, K., *Field Theory in Social Sciences*, edited by S. D. Cartwright (1951).

²⁰ Cf. Goldstein, K., *The Organism* (1939), pp. 291-340 and Frank, L. K., *Nature and Human Nature* (1951).

²¹ James, W., *Psychology* (1948), pp. 176-216.

²² Among those whose writings have been cited are Allport, Murphy, Rogers, Snygg, Combs, French, Horney and Sullivan.

egos as there are different social groups and strata with which he is connected." ²³

To most of these writers, however, the concept of self or ego seems to refer primarily to the conscious system of attitudes and values with which an individual identifies in a given situation. What has been known in psychoanalytic literature as the Id or the Unconscious, that is, impulses and behavior patterns characterized by low degrees of awareness has not been adequately accounted for. One may ask here: Are those impulses and behavior patterns that the clinicians deal with really as primitive and as instinctive as the word Id would signify and do they come directly into conflict with the individual's self-picture of the moment or with Freud's Superego formed in the early genital period of his psychosexual development; or are they rather what Dewey called "habits" organized around roles or self-concepts that the individual has acquired early in life? ²⁴ These questions are not adequately answered by such designations as "neurotic trends" (Horney), or "dissociated tendencies" (Sullivan), or autonomous motives (Allport), or plain unacceptable impulses. If the concept of self or ego is used to refer to the organization of those experiences that an individual had in his primary group environment but that now are repressed or dissociated, we are not told what becomes of those selves acquired early in an individual's life and how they are related to his self-concept of the moment and incorporated into his personality as a whole. The answer to these questions, it seems to the writer, may lie in the concept of primary self as it is used in the foregoing propositions regarding personality organization.

Some of the clinical observations in support of the concept of the primary self have already been mentioned. Further evidences justifying the use of the concept may be found in the so-called transference phenomenon and in the self perceptions often dramatized in the dreams. The former, as all users of intensive psychotherapy can testify, is essentially a relationship in which a patient, knowingly or unknowingly, identifies the treatment situation with his primary group environment and the therapist with the most significant persons in that environment. In other words, in his relations with the therapist at the present time the patient is actually playing a role, or acting according to a self-concept, that he has acquired in his primary group environment, although at the same

²³ Sorokin, P. A., *Society, Culture and Personality* (1947), p. 345.

²⁴ Dewey, J., *Human Nature and Conduct* (1922), p. 89.

time he may feel that he ought to act differently or more according to a self-concept appropriate to the real situation. In fact, learning to differentiate between the two constitutes the very essence of the therapeutic process. Such distorted definitions of present-day situations are often dramatized with the most uncanny accuracy in the patient's dreams and they usually take the form of perceiving an on-going interpersonal situation in terms of self-other relations in his primary group environment.²⁵

A pertinent question may be asked here. Since there are more than one person in the primary group and since the concept of self implies a self-other relationship, can we say then that there are as many primary selves in an individual's personality as there are persons in his primary group? Logically, the answer seems to be in the affirmative. But empirically and clinically, what we do very often find is that there are always certain key persons in an individual's primary group and certain key experiences that are especially related to the kind of primary self he has acquired. In fact, we may follow Mead and say that what we refer to here is a generalized self that has resulted from the child's taking the role of the primary group "community" as a whole.²⁶ It is a self-picture that reflects the child's role in the total context of his first socio-cultural environment.²⁷

Another related question may be asked. Does this concept of the primary self that has been derived principally from clinical observations apply to the normals, that is individuals who do not appear to have psychiatric symptoms and who do not seek treatment? That it does is strongly suggested by such intensive studies as that of a successful business man, named Orvil, by William Healy²⁸ and those of over 30 graduate students in psychiatry, clinical psychology, and medicine, made by the writer strictly for purposes of training.²⁹ In fact, a certain amount of such distorted

²⁵ Freud, S., *The Interpretation of Dreams*; Lowy, S., *Psychological and Biological Foundations of Dream Interpretation*, 1946.

²⁶ Mead, G., *Mind, Self and Society* (1934), pp. 142, 167. It is to be noted that Mead makes a distinction between the self in its cognitive aspects and the self in its affective aspects (p. 173). This paper admittedly emphasizes the latter.

²⁷ For a clinical application of this approach, see B. Dai, "Divided Loyalty in War: A Study of Cooperation with the Enemy," *Psychiatry* 7 (1944), pp. 327-340.

²⁸ Healy, W., *Personality in Formation and Action* (1938), pp. 53-69.

²⁹ Each of these trainees was given a 3-month intensive personality study,

definitions of present-day situations in terms of primary group relations seems to be the rule instead of an exception with the normals, and the exponents of the interpersonal theory have insisted that this phenomenon they call parataxia deserves more of the attention of the social scientists than it has been given.³⁰

There are other interesting theoretical problems connected with the concept of primary self that we cannot go into here for lack of time. Perhaps the process of self formation and some of its practical implications may be worth a special mention. In the first stage of the development of the primary self, the interaction between the individual and the representatives of his primary group environment probably takes the form of the interplay of what Plant called "psychomotor tensions" ³¹ and the process involved is probably what Sullivan called "empathy." ³² As the child's language ability develops, the process may be more properly called "symbolic interaction," ³³ or in Mead's own terms, "the conversation of significant gestures." ³⁴ In terms of the sequence of events that can be readily reconstructed in the life history of any patient, the steps involved in the formation of the primary self seem to be as follows: first, the significant persons in his primary group environment have felt, thought and acted toward him in a certain way; then he as a child has learned to feel, think and act toward himself in a similar way; and finally, since no important corrective experiences have intervened, he has acquired the type of primary self that we spend a lot of time in discovering and helping to modify in the clinic.³⁵

If problems of behavior disorders can be best understood in terms of man's continuous and persistent efforts to be human since infancy, that is to achieve a self-picture acceptable to himself as well as to other humans, therapeutic implications of the approach are obvious. Instead of centering one's attention on the vicissitudes of an instinct from infancy on or any other causal factor required by the various schools of psychopathology, the therapist's principal

consisting of 36 didactic interviews, as a part of a program of training in psychotherapy conducted by the writer in the Departments of Psychiatry and Psychology, Duke University.

³⁰ Beaglehole, E., "Interpersonal Theory and Social Psychology," *A Study of Interpersonal Relations*, edited by P. Mullahy (1949), pp. 50-79.

³¹ Plant, J., *Personality and the Cultural Pattern* (1937), p. 21.

³² Sullivan, H. S., *Conceptions of Modern Psychiatry* (1946), p. 8.

³³ Coutu, W., *Emergent Human Nature* (1949), pp. 281-300.

³⁴ Mead, *op. cit.*, pp. 138-139, 167, 191, 364-370.

³⁵ Cf. Rogers, *Client-Centered Therapy*, pp. 481 ff.

job will be to find out what type of a primary self the individual has acquired in the course of his relations with his primary group environment and how this primary self together with the behavior patterns it has produced are now interfering with the individual's attempt at realizing the self-picture he considers as more appropriate to his present-day socio-cultural environment. The types of primary self one may find differ with the individual and with his specific primary personal and cultural environment, and may, in fact, require different therapeutic procedures. Problems related to the handling of biologic impulses will not be ignored, but they will be approached always in the context of the individual's personality organization as a whole and especially in that of his efforts to be human, that is to achieve the kind of self-picture that he can be proud of in relation with other humans. From this point of view, therapeutic relations will be no mere occasions for the recapitulation of the various stages of libidinal development, but primarily experiences through which an inadequate primary self-concept is modified or a new self-picture is developed. Nor does the therapeutic process seem to be simply a matter of internal perceptual reorganization on the part of the individual as Rogers described it,³⁶ for we can be reasonably sure that no such perceptual reorganization can take place in a social vacuum. In fact, it appears to be literally a process in which a new self appears through a new kind of symbolic interaction, which the individual now experiences for the first time in his life. The steps involved seem to be the same through which the primary self first emerges. First, the therapist feels about and responds to him and his problems in a certain way; then, the patient learns to do the same to himself and his problems; and finally, if the therapist succeeds in performing his professional role and the patient's assets permit, a new and more acceptable self may emerge. A remarkable study of the steps involved in the recovery of a schizophrenic patient made by a Swiss lay analyst, Mrs. Secheyay, seems to indicate that the therapeutic process described here is true not only of cases with behavior disorders of the neurotic variety, with which the writer has a fair amount of familiarity, but of the more severe cases as well.³⁷

The socio-psychiatric approach to personality organization as outlined here may also have some rather far-reaching implications

³⁶ Rogers, C. R., "Personality Organization," *Psychological Theory*, edited by M. H. Marx (1951), pp. 517-521.

³⁷ Secheyay, M. A., *Symbolic Realization* (1951), pp. 136-137.

for mental hygiene. According to this view, the most important job in bringing up children is not so much to see that isolated biologic needs are gratified or that specific habits are established as that, through all these need-gratifications and habit-formations, an adequate and favorable primary self-picture is developed. This may mean that we will have to learn to treat the infant as a human being with self-concepts in the process of becoming and not merely as a bundle of reflexes to be severally conditioned or as a concentration of libidinal energy to be zonally discharged. If our description of the process of self-formation is correct, it follows that in order to give the child the proper role to take and thereby to enable him to develop the proper kind of self-concept and eventually become a self-respecting and self-trusting human being among other humans, it may not be quite sufficient for parents just to learn to master the methods of administering rewards and punishments, as some authors seem to think,³⁸ or even to indoctrinate the child in the best religious teachings of the world.³⁹ Child rearing methods and ethical principles by themselves may be of little avail unless parents themselves and those having direct dealings with the child have achieved self-concepts of such a kind that they will not, wittingly or unwittingly, utilize their relations with the child mainly for the gratification of their own private needs. Only in this manner can they genuinely and consistently love and respect the child as an individual, and only in this manner can the child, in turn, learn to love and respect himself as a human being and eventually acquire the kind of adequate and growth-facilitating primary self that seems to be the only true foundation of mental health.⁴⁰

³⁸ Hohman, L. B., *As the Twig Is Bent*, 1940.

³⁹ Moore, D. T. V., *Personal Mental Hygiene*, 1944.

⁴⁰ Dai, B., "Freedom, Discipline and Personal Security," *Progressive Education*, January, 1949.

Infant Training and Personality of the Child *

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IN RECENT years a great deal has been written about the influence of child training on personality formation and development.¹ In particular, these writings have stressed the crucial role of infant discipline in character formation and personality adjustment. As Orlansky has pointed out, in general, writers of this conviction have taken as proved the genetically and biologically oriented psychoanalytic assumption that the specific channeling of infantile physiological urges by parents produces specific psychological constellations in the individual.² For the most part the evidence

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¹ No attempt will be made here to review the literature. R. R. Sears has surveyed objective studies designed to test psychoanalytic theory in his *Survey of Objective Studies of Psychoanalytic Concepts* (New York: Social Science Research Council, 1943) and in his "Experimental Analysis of Psychoanalytic Phenomena" in J. McV. Hunt, *Personality and the Behavior Disorders* (New York: Ronald Press, 1944). The pertinent empirical studies are well summarized in an article by Harold Orlansky, "Infant Care and Personality," *Psychological Bulletin*, No. 46 (January, 1949), pp. 1-48. Since that time a significant empirical study has been published by John R. Thurston and Paul H. Mussen, "Infant Feeding Gratification and Adult Personality," *Journal of Personality*, XIX (June, 1951), 449-58. A. R. Lindesmith and A. L. Strauss have made a critical review of the literature on culture and personality in their "Critique of Culture-Personality Writings," *American Sociological Review*, XV (October, 1950), 587-600.

² A more sociological position is outlined in a paper by Robert F. Winch,

brought to bear on these assumptions by the psychoanalytic school has been based on clinical observations of adults, with subsequent reconstruction of training experiences as an infant, rather than on empirical studies of the relation between observed experiences of infancy and personality traits.³ The danger in this procedure is that the reconstruction of infant experiences may be erroneous, and even if not there is no way of knowing that those who are clinically treated differ from the general population in the infant training they have undergone. The lack of attention to alternative hypotheses, to negative evidence, and to adequate statistical and experimental techniques and standards means in the final analysis that the psychoanalytic assumptions have not been adequately tested, much less scientifically established by the psychoanalytic group.

This has in no way deterred certain writers from ascribing the main features of the character structure and culture of whole societies to specific infant disciplines supposedly common in that society.⁴ Even more serious, many pediatricians, clinical psychologists, family counselors, and other practitioners have accepted psychoanalytic theory on faith and have strongly advocated systems of infant care which they believe follow logically from the Freudian position. Thus they emphasize breast feeding, a prolonged period of nursing, gradual weaning, a self-demand nursing schedule, easy and late bowel and bladder training, frequent mothering, freedom from restraint, freedom from punishment, sleeping with the child, and so on. They have assumed that these practices will promote the growth of secure and unneurotic personalities.

Recently, critics of the psychoanalytic position have reviewed the empirical evidence from a number of studies, most of which were either not designed to test the influence of infant training on personality or were not adequate to test the relationship. Orlansky in his critical study of existing empirical research concluded that there are relatively few studies which systematically

"The Study of Personality in the Family Setting," *Social Forces*, XXVIII (March, 1950), 310-16.

³ See Orlansky, *op. cit.*, pp. 1-2.

⁴ See particularly the following: G. Gorer, *The American People* (1948); Erik H. Erikson, "Childhood and Tradition in Two American Tribes," in Clyde Kluckhohn and Henry A. Murray, *Personality, in Nature, Society, and Culture* (New York: Alfred A. Knopf, 1948); and Weston LaBarre, "Some Observations on Character Structure in the Orient," *Psychiatry*, VIII (1945), 319-42, and IX (1946), 375-95.

explore the relationship between infant discipline and personality, that the data available are of questionable value, but that the evidence permits a negative conclusion as to the effect of infant-training practices on personality.⁵ Lindesmith and Strauss concluded from their study of the culture-personality literature that the effects of infant experience on personality are undemonstrated.⁶ This was essentially the position to which the writer had come when this study was undertaken. Dissatisfaction with the scientific adequacy of the existing studies prompted me to obtain detailed data on various aspects of infant-training practices in a field study of social factors and personality adjustment which was begun in 1947.

The purpose of the present paper is to report the results of this study which bear directly on the relationship between the actual infant-training of a group of children and their personality adjustments and traits, as indicated by scores on pencil-and-paper and projective personality tests, ratings by teachers, and behavioral information gained from interviews with their mothers.

THE STUDY DESIGN

The data for this study consist of detailed information on the infant-training experiences of 162 farm children of old American stock and the results of their ratings on various personality measures. In the design of the study an attempt was made to approximate experimental conditions by the prior control of several factors believed to be associated with personality adjustment. Thus diverse cultural influences were eliminated by selecting only children of old American cultural backgrounds in a predominantly old American community. By selecting children from a single occupational group (farm children), occupational and socioeconomic influences were roughly controlled. Age was held constant by selecting only children in the age group five to six. Personal-social experiences were in some measure controlled by the selection of children who had not yet been subject to the socializing effects of school. Only the children of unbroken and never broken unions were selected; consequently, disrupted family situations could not affect the findings. It was not possible to control other factors which might have influenced the results, because of the difficulty and costs of

⁵ *Op. cit.*, p. 2.

⁶ *Op. cit.*, pp. 596-99.

obtaining a large enough sample to permit the type of statistical treatment planned; but even this rough approach to experimental conditions should make feasible a much more rigorous and satisfactory testing of the relationship between infant-training and personality than has been possible to date.

The data on the infant-training practices which the children had undergone were obtained from a personal interview with the mother. The interview was conducted in the home of the child by a highly trained interviewer, using guided interviewing techniques. Great attention was given to the planning and execution of the field interviews, so that dependable data would be forthcoming from the mothers.⁷ The interview actually covered many aspects of parent-child relations, family relations, community relations, and family structure, but particular attention was focused on the personal-social experiences of the child under study—especially in relation to the specific training he had undergone during infancy and early childhood and to his personal adjustments in the family situation.

The data from these interviews were coded and punched on IBM cards. Examination of the schedules and preliminary analysis indicated that adequate data were available on the following specific infant-training practices: manner of nursing, nursing schedule, weaning, bowel training and bladder training, punishment for toilet accidents, and sleep security. Included in this list are most of the practices to which major attention has been given in the literature. They were defined as shown in Table 1.

The personality data are of three types: (1) over-all ratings of personality adjustment based on scores on standardized and unstandardized personality tests of both the paper-and-pencil and the projective types; (2) scores or ratings on personality components derived from the personality adjustment tests; (3) personality behavioral manifestations, based on interviews with the mothers or on teachers' ratings of the child's behavior. These data were obtained from tests administered by a trained clinician, who tested the children early during their first year in school, from teachers' ratings of the child, and from information supplied by the mother in the course of the original interview.

⁷ For a full discussion of the field techniques and the factors covered in the interview see William H. Sewell, "Field Techniques in Social Psychological Study in a Rural Community," *American Sociological Review*, XIV (December, 1949), 718-26.

TABLE 1

* Practices	No. of Cases	Definition
<i>Manner of nursing:</i>		
Bottle fed	43 *	Exclusively bottle fed from birth to weaning
Breast fed	60	Exclusively breast fed from birth to weaning
<i>Nursing schedule:</i>		
Regular	110	Nursed on a regular time schedule
Self-demand	52	Nursed on a self-demand basis
<i>Weaning:</i>		
Abrupt	23	Child abruptly taken from bottle or breast feeding and shifted to other foods
Gradual	139	Child gradually shifted from bottle or breast feeding over to other foods
<i>Bowel training:</i>		
Early	95	Began before the child was 12 months old
Late	67	Began after the child was 12 months old
<i>Bladder training:</i>		
Early	80	Began before the child was 12 months old
Late	82	Began after the child was 12 months old
<i>Punishment for toilet accidents:</i>		
Punished	92	Physical or verbal punishment for bowel and bladder accidents
Not punished	70	No physical or verbal punishment for bowel and bladder accidents
<i>Sleep security:</i>		
Low	119	Slept alone during first year of life
High	43	Slept with mother during first year of life

* Fifty-nine cases are excluded from the analysis of this item because they experienced both bottle and breast feeding.

The principal measures of personality used in the study were the California Test of Personality (Primary Form A), the Ford modification of the Haggerty-Olson-Wickman Behavior Rating Scale, the Wisconsin Test of Personality, and a General Adjustment Index developed from the interview data. The California Test of Personality is a widely used paper-and-pencil test for children of this age.⁸ It consists of 96 items which are grouped under 12

⁸ For a description of this test, including its standardization and a review of studies in which it has been used, see *California Test of Personality: Summary of Investigations No. 1* (Los Angeles, Calif.: California Test Bureau, 1947); and L. P. Thorpe, W. W. Clark, and E. W. Tiegs, *Manual of Direc-*

components, 6 of which produce a self-adjustment score and the remaining 6 a social adjustment score. The 12 component indexes commonly have been used for trait or component analysis. The Ford modification of the Haggerty-Olson-Wickman Behavior Rating Scale consists of several of the more important ratings made by the child's teacher on acceptance of authority, reaction to frustration, self-assertiveness, emotional responses, and school behavior.⁹ The Wisconsin Test of Personality is a projective test which was developed by Mary Simpson for use on children in the age group six to ten.¹⁰ It consists of 10 unstructured water-color pictures (similar to TAT cards) about which the child is asked to tell a story. This story is taken down verbatim by the clinician, and the resulting protocols are scored according to a "need-press" system in essentially the same fashion as the TAT. In this study the protocols were "blind-scored" by the author of the test. The General Adjustment Index is a crude rating constructed for the purposes of this study from data available from the interview with the mother. It consists of information on the child's nervous symptoms and emotional adjustments in the family situation. Subscores on nervous symptoms and emotional adjustments are available also from this index, and the single behavioral items may be examined separately as personality behavior manifestations.

From the tests, their components, and the individual items, it is possible to extract a number of personality assessments for the children included in the study. These fall into the three groups shown in Table 2.

tion: California Test of Personality—Primary Series (Los Angeles: California Test Bureau, 1947). Although its validity is not established, this test has been widely used in sociological studies. It has recently been employed in a study of rural children in Ohio by A. R. Mangus. See especially his "Personality Adjustment of Rural and Urban Children," *American Sociological Review*, XIII (October, 1948), 566-75; see also Joseph Jacobson's articles on the validity of this test: "A Mutual Validation of Personality Tests," *Journal of Social Psychology*, XXII (1945), 195-202, and "The Relative Effectiveness of Paper and Pencil Tests, Interview and Ratings as Techniques for Personality Evaluation," *ibid.*, XXIII (1946), 35-54.

⁹ See Mary Ford, *The Application of the Rorschach Test to Young Children* (Minneapolis: University of Minnesota Press, 1946). For a discussion of the scale see M. E. Haggerty, W. C. Olson, and E. K. Wickman, *Scales for the Study of Behavior Problems and Problem Tendencies in Children* (New York: World Book Co., 1930).

¹⁰ This test has not been published. It was standardized on a sample of rural and urban Wisconsin children. The ten pictures were selected by item-analysis techniques from sixty pictures designed for this test.

TABLE 2

GENERAL ADJUSTMENT MEASURES	
Total adjustment score *	Personality adjustment rating †
Social adjustment score *	Teachers' rating of child's adjustment ‡
Self-adjustment score *	General adjustment index §
COMPONENTS	
Self-reliance *	Social skills *
Sense of personal worth *	Antisocial tendencies *
Sense of personal freedom *	Family relations *
Feeling of belonging *	School relations *
Withdrawing tendencies *	Community relations *
Nervous symptoms *	Nervous symptoms §
Social standards *	Emotional adjustment §
BEHAVIOR MANIFESTATIONS	
Aggression (total) §	Eating troubles §
Arguing §	Penuriousness §
Fighting §	Acceptance of authority ‡
Temper (extent) §	Self-assertiveness ‡
Temper (demonstration) §	Reaction to frustration ‡
Biting nails §	Emotional responses ‡
Sucking fingers—now §	School behavior ‡
Sucking fingers—baby §	Crying §
Stuttering §	Sleep disturbances §
Fears §	Cautiousness §
Learning to talk §	Cuddling §
Bashfulness §	Jealousy §
Feelings hurt §	Happiness §

* From California Test of Personality.

† From Wisconsin Test of Personality.

‡ From Ford modification of the Haggerty-Olson-Wickman Behavior Rating Scale.

§ From interview with child's mother.

STATISTICAL ANALYSIS

Because no great claim can be made for either the precision, the validity, or the reliability of any of the personality tests, indexes, or items and because the sample size is not great, no attempt is made in this study to use any of them as quantitative measures.¹¹ Rather,

¹¹ It is not at all clear what the theoretical basis has been for most of the personality tests now in existence. Many have been developed to distinguish between "neurotic" and "normal" persons. To my knowledge, no test has been developed which takes adequate account of the adjustment of the individual in the social roles which he is expected to play in the particular

each is used only as a crude indicator. Thus, in the case of the tests and components, the child's score on each of the personality indexes was computed, an array of scores was cast for each measure, and two relative score groups of approximately equal size were established.¹² The only assumption made was that those who made scores or ratings in the top-half of the distribution were better adjusted as a group than those who made scores which placed them in the lower half of the distribution. Likewise, responses on the individual behavioral items were classified simply as "Favorable" or "Unfavorable." The categories derived from this process were then punched on the IBM cards containing the infant-training data.

In the actual statistical analysis the association between each of the seven infant-training practices and each of the forty-six personality indicators was determined by applying the chi square test to the fourfold tables which were obtained by cross-sorting the training practice responses with the dichotomized personality variables. The chi square test is, of course, a crude test of significance but probably is as precise as the data justify. The level of significance set for this study is the 5 per cent level.

THE HYPOTHESES

The data from the foregoing analysis make possible the testing of a number of pertinent hypotheses about the influence of infant training on personality adjustment. In fact, in the strictest sense, null hypotheses might be set up by making a separate hypothesis for the relationship between each training item and each personality item. However, to save space and avoid repetition, one general hypothesis concerning the relation of infant-training to personality adjustment and several specific hypotheses concerning the relation between particular training practices and personality adjustment were formulated. The general hypothesis, stated in the null form, is that *the personality adjustment and traits of children who have undergone varying infant-training experiences do not differ significantly from each other*. The specific null hypothe-

social systems in which he functions. In my opinion, tests of this type are necessary to sociologically relevant studies of personality, but, lacking them, existing tests must be used.

¹² It was not possible to follow this procedure with the Wisconsin Test of Personality. Consequently, only those children whose protocols indicated disturbed personalities were placed in the unfavorable group, and all others were classified as favorable.

ses covering each of the training practices are stated in the section on results, which follows.

RESULTS

It will not be possible because of space limitations to present the several hundred fourfold tables upon which the analysis that follows was based. However, Table 3 contains in summary form all the significant relations that were found between training practices and the various indicators of personality adjustment employed in this study. A supplement to this paper has been prepared which gives all the fourfold tables used to test the hypotheses of the study. This has been filed with the American Documentation Institute and is available to anyone who wishes to examine the basic tables.¹³

TABLE 3

Training Practice and Indexes	Indicators of Personality Adjustment	X ²	P
Self-demand feeding schedule	Low feeling of belonging *	3.91	0.05
Gradual weaning	High feeling of belonging *	5.83	0.02
Gradual weaning	High social standards *	4.61	0.05
Late bowel training	Poor school relations *	4.51	0.05
Late bowel training	Good temper †	9.26	0.01
Late bowel training	Little nail biting †	4.32	0.05
Late bladder training	Little nail biting †	9.22	0.01
No punishment for toilet accidents	High social adjustment *	8.76	0.01
No punishment for toilet accidents	High social standards *	8.30	0.01
No punishment for toilet accidents	Good school relations *	6.74	0.01
High sleep security	Low self-adjustment *	4.67	0.05
High sleep security	Low personal freedom *	5.87	0.02
High sleep security	Poor family relations *	4.12	0.05
High sleep security	Sleep disturbances †	3.93	0.05
High infantile security	High personal freedom *	4.82	0.05
High infantile security	Good temper †	4.03	0.05
Favorable toilet training factor	Little nail biting †	6.71	0.01
Favorable feeding training factor	Poor family relations *	6.03	0.01

* From California Test of Personality.

† From interview with the child's mother.

¹³ For the detailed tables, order Document 3623 from American Documentation Institute, 1719 N Street, N.W., Washington 6, D.C., remitting \$1.00

On the basis of the results of the statistical tests, the first specific hypothesis that *the personality adjustments of the children who were breast fed do not differ significantly from those of the children who were bottle fed* cannot be rejected. None of the forty-six possible chi squares is statistically significant.

Likewise, the second specific hypothesis that *the personality adjustments of the children who were fed on a self-demand nursing schedule do not differ significantly from those of the children who were fed on a regular schedule* cannot be rejected. On the basis of the statistical tests, only one association is significant (see Table 3). The children fed on a self-demand schedule during infancy have significantly lower feelings of belonging, according to their scores on this component of the California Test of Personality, than do those fed on a regular schedule. This is contrary to the relationship expected on the basis of the theory.

The third specific hypothesis that *the personality adjustments and traits of the children who were weaned gradually do not differ significantly from those of the children who were weaned abruptly* cannot be rejected on the basis of the statistical evidence (see Table 3). Of the forty-six chi squares, only two are significant. The children who were weaned gradually make a more favorable showing on the social standards and feeling of belonging components of the California Test of Personality than do the children who were weaned abruptly. These results are in keeping with the prediction that one would make on the basis of the theory. However, there are no significant differences on any of the other measures.

The fourth specific hypothesis that *the personality adjustments and traits of the children whose induction to bowel training was late do not differ significantly from those of the children whose induction was early* likewise must not be rejected. Again only three of the possible chi squares are significant¹⁴ (see Table 3). Children

for microfilm (images 1 inch high on standard 35-mm. motion-picture film) or \$1.50 for photocopies (6 X 8 inches) readable without optical aid.

¹⁴ Some readers may wonder exactly how many differences would have to be significant before the null hypothesis would be rejected. Unfortunately, there is no accepted standard for rejection of the null hypothesis in situations of this kind where there is probably some intercorrelation between the variables but where in no sense the forty-six personality indicators can be thought of as measures of the same thing. I have discussed my results with several mathematical statisticians, who agree that the null hypotheses of this study cannot be rejected on the basis of the statistical evidence, but none of them has been willing to set an unequivocal standard.

whose induction to bowel training was late made a less favorable showing on the school relations component of the California Test of Personality, had better tempers, and were less likely to bite their nails than those whose induction was early. The latter two findings are in keeping with the theoretical predictions, but the first is not.

The fifth hypothesis that *the personality adjustments and traits of the children whose induction to bladder training was late do not differ significantly from those of the children whose induction was early* must not be rejected. There is only one significant chi square (see Table 3). Those with late bladder training were less likely to bite their nails than those with early bladder training. This association is in the expected direction.

The sixth hypothesis that *the personality adjustments and traits of the children who were not punished for toilet training accidents do not differ significantly from those of the children who were punished* must not be rejected (see Table 3). Only three of the chi squares are significant. Those who were not punished for toilet training accidents made better showings in the social adjustment, social standards, and school relations components of the California Test of Personality. These results are in keeping with the prediction that would be made on the basis of the writings about this training practice.

The seventh hypothesis that *the personality adjustments of the children who slept with their mothers during infancy do not differ significantly from those of the children who did not sleep with their mothers* must not be rejected (see Table 3). Four of the possible chi squares were significant. The children who slept with their mothers during infancy made significantly poorer showings on the self-adjustment, personal freedom, and family relations components of the California Test of Personality and suffered more sleep disturbances than did those who slept alone. The direction of these associations is contrary to what would be expected on the basis of the theory but are the most consistent results yet found in the study. Obviously, they contradict the claim of those who hold that this practice promotes secure childhood personalities.

Because it was not possible on the basis of the analysis to reject any of the specific null hypotheses concerning the association between training experiences and personality adjustments and traits, the general null hypothesis that *the personality adjustments and traits of the children who have undergone varying infant-training*

experiences do not differ significantly cannot be rejected. However, before reaching this unequivocal conclusion, it was decided that some attempt should be made to determine the joint effects of the several infancy experiences on personality adjustment. Consequently, a crude index was developed to indicate degree of infantile security. This index was based on the simple assumption that the combined effects of the various training experiences which are believed to be favorable would produce a more favorable infancy than would the combined effects of those training experiences which are assumed to be unfavorable. In arriving at the index scores, one point was given for each of the supposedly favorable infant-training experiences, and a total was computed. Following the procedure used throughout the study, the resulting distribution was approximately halved, to produce favorable and unfavorable categories, and forty-six fourfold tables were produced relating the infantile security index to the personality indicators. This made possible the testing of an eighth null hypothesis that *the personality adjustments and traits of the children whose infantile security index scores are favorable do not differ significantly from those of the children whose scores are unfavorable*. This hypothesis, too, must not be rejected on the basis of the statistical analysis (see Table 3). Of the forty-six possible chi squares, only two are significant. The children with more favorable scores had better tempers and a higher sense of personal freedom than did those whose scores were unfavorable on the index of infantile security. These relationships are in the expected direction, but the over-all results of this analysis provide no basis for the rejection of either the specific or the general hypothesis.

As one phase of the larger study of social factors and personality adjustment of which the present paper is a part, a factor analysis has been made of thirty-eight child-training practices, in order to isolate meaningful constellations of practices.¹⁵ As a result of this analysis, six factors have been isolated, two of which contain items which are in the infant-training period; one on the toilet training complex and the other on the feeding training complex. Factor

¹⁵ The factoring procedure was the modified multiple-group method of C. W. Harris and John Schmidt, Jr. See their article, "Further Application of the Principles of Direct Rotation in Factor Analysis," *Journal of Experimental Education*, XVIII (March, 1950), 175-93. The computation of the factor scores was done by Lederman's shortened method as generalized by Karl J. Holzinger and Harry J. Harman, *Factor Analysis* (Chicago: University of Chicago Press, 1941), pp. 278-88.

scores were derived for the children on these two factors, the distributions were again divided into favorable and unfavorable groups, and fourfold tables were produced relating these factors to all the personality measures. This made possible the further testing of the original general hypothesis and a ninth and tenth hypothesis dealing with the specific factors. Thus, the ninth hypothesis is that *the personality adjustments and traits of the children whose toilet training factor scores are favorable do not differ significantly from those of the children whose scores are unfavorable*. This hypothesis cannot be rejected. Actually, only one of the possible forty-six chi squares is significant; children whose toilet training factor scores are favorable are less likely to bite their nails than are those whose scores are unfavorable (see Table 3). Likewise, the tenth hypothesis that *the personality adjustments and traits of the children whose feeding training factor scores are favorable do not differ significantly from those of the children whose scores are unfavorable* cannot be rejected (see Table 3). Again, only one of the possible chi squares is significant; children whose feeding training scores are more favorable score lower on the family relations components of the California Test of Personality than do those whose feeding scores are less favorable. Again, the results of the testing of these two hypotheses in no way change the judgment that the general hypothesis of no significant relation between the infant training and the personality adjustments of the children studied must not be rejected.

SUMMARY AND CONCLUSIONS

On the basis of the results of this study, the general null hypothesis that the personality adjustments and traits of children who have undergone varying training experiences do not differ significantly cannot be rejected.¹⁰ Of the 460 chi square tests, only

¹⁰ Some may raise question as to whether the association between the infant-training practices and the personality indicators would have been more marked if (1) more precise statistical measures had been used or (2) only the children who differed more markedly in their personality adjustments had been compared. Both these possibilities were tested and in no way improved the association. Means on the various personality tests and components were computed and tested for significance by the use of the critical ratio technique. Not only were the differences in means nonsignificant, but in all cases differences were extremely small and inconsistent in direction. Likewise, when only the children whose personality adjustment

18 were significant at or beyond the 5 per cent level.¹⁷ Of these, 11 were in the expected direction and 7 were in the opposite direction from that expected on the basis of psychoanalytic writings. Such practices as breast feeding, gradual weaning, demand schedule, and easy and late induction to bowel and bladder training, which have been so much emphasized in the psychoanalytic literature, were almost barren in terms of relation to personality adjustment as measured in this study.¹⁸ Actually, these 6 factors produced only 11 significant chi squares out of a possible total of 276. Of these, 9 are in the direction which would be predicted on the basis of psychoanalytic writings and 2 are in the opposite direction. The practice which produced the largest number of significant chi squares was "slept with mother during first year of life." There were 4 significant chi squares, but all of them were in the opposite from the predicted direction. The two factor indexes and the index constructed to measure the cumulative effects of the infant-training practices produce even more meager results. Only 4 of a possible total of 138 chi squares were statistically significant; 3 were in the predicted and 1 in the opposite direction from that expected on the basis of psychoanalytic writings.

It is also interesting to observe that none of the training experiences was significantly related to any of the major tests of personality adjustment. The few significant relationships that were found tend to scatter widely among the various personality components and behavioral items; consequently, it cannot be held that any of the personality indexes or traits is consistently related to infant discipline.

Certainly, the results of this study cast serious doubts on the validity of the psychoanalytic claims regarding the importance of the infant disciplines and on the efficacy of prescriptions based on them. However, it should not be concluded that these results un-

scores placed them in the extreme quartiles were compared, the results were no more significant than when the original dichotomous adjustment categories were used.

¹⁷ It should be pointed out that there was no consistent trend in the direction of association (whether significant or not) between the infant-training items and the personality indicators. Of the 460 chi squares, 215 were in the predicted and 245 were in the opposite direction from that expected on the basis of psychoanalytic writings.

¹⁸ The findings of the present study are in agreement with the more carefully designed empirical studies which Orlansky cites (*op. cit.*, pp. 3-21) and with the recent study by Thurston and Mussen (*op. cit.*, pp. 456-57).

equivocally refute the claim that infancy is an important period in the development of the individual's personality, or even that the particular training practices studied have a bearing on personality formation and adjustments. To establish the first point would demand both controlled experiments and the study of other aspects of infancy. To establish the second point would demand the corroboration of the results of this study by many and better-designed studies of different culture and age groups.¹⁹

It is entirely possible that the significant and crucial matter is not the practices themselves but the whole personal-social situation in which they find their expression, including the attitudes and behavior of the mother.²⁰ This aspect of the mother-child relationship was purposely excluded from this paper. To a great extent it has escaped the net that was cast in the larger study of which this is a part and in other studies of infant training.²¹ Much work must be done to devise techniques which will give at least crude measures of these qualitative aspects of the personal-social situation if the importance of infancy on personality formation and adjustment is to be assessed adequately. However, assumptions about the importance of the personal-social situation should be put to scientific test before any more unfounded personality theories and practices are built upon them.

Finally, a word is in order about the limitations of this study. First, it must be admitted that the controls employed, although better than in most studies of this type, were very crude; consequently, factors not accounted for may have affected the findings. Second, the data on training experiences, although gathered and treated with care, may be inadequate for reasons cited or unknown.

¹⁹ It may well be that the full effects of infant discipline will not become apparent until the children reach adulthood. However, Thurston and Musen (*loc. cit.*) found no relationship between infant feeding gratifications and adult personality. The plan of the present research is to follow the children as far as possible throughout their development.

²⁰ This point has been suggested by several writers, including Erich Fromm. See his "Psychoanalytic Characterology and Its Application to the Understanding of Culture" in S. S. Sargent and M. W. Smith (eds.), *Culture and Personality* (New York: Viking Fund, 1949). However, I know of no scientific study of the personality adjustments of persons who have actually undergone the same infant-training experiences in varying personal-social contexts.

²¹ Limited data are available on this point from the larger study. A paper is planned which will report the influence of parent-child relationships on childhood personality adjustments.

Third, the measures of personality employed in the study are far from perfect in relation to either their validity or their reliability. Consequently, the possibility remains that the results may be different when the children are tested at later periods in their development and with more satisfactory measures.²² But, despite these and other limitations, the results of this study are unequivocal for the sample covered, and their generality must be affirmed or denied by means of better-designed and executed empirical studies, not by dialectic.

²² The children will be tested again in 1952. It is hoped that, as they grow older, it will be possible to use more adequate means of assessing their personalities, first, because better tests are available for older children and adults and, second, because it is expected that more adequate tests will be developed as time goes on.

The Middle-Class Male Child and Neurosis*

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IN ANOTHER publication,¹ Erich Fromm's and Karen Horney's use of general-cultural data to explain neurosis was criticized. It was pointed out that while these two analysts have a concept of cultural neurosis (Horney) and pathological normalcy (Fromm), from which "the culture" is suffering, at the same time a clinical picture of neurosis is presented without reference to culture—the going awry of personal relationships, particularly of the child-in-family. While in her earlier work in this country Dr. Horney found love-frustration the key to the individual etiology of neurosis,² later, and indicating Dr. Fromm's influence, the key became the arbitrary imposition of authority within the family of orientation.³

* From *American Sociological Review*, 11 (February, 1946), 31-41. Reprinted by permission of the author and the publisher.

¹ Arnold W. Green, "The Sociological Analysis of Horney and Fromm," *American Journal of Sociology*, 51 (May, 1946), 533-540.

² *Neurotic Personality of Our Time* (W. W. Norton & Co., N.Y., 1937, xii and 299 pp.) page 80: The "basic evil is invariably a lack of genuine warmth and affection." Since "love" represents a not too radical departure from "libido" and "Oedipus," it is not surprising that the initial revolt against Freudian theory should find Freudian-trained analysts huddling close to the fence of familiar pastures. See, for example, Adolph Stern, "Psychoanalytic Therapy in the Borderline Neuroses," *The Psychoanalytic Quarterly* (1945) 14: 190-198. Stern finds "affect-hunger," especially in the relationship of mother and child, the root of borderline neuroses. The revolt probably stems more from a distaste of the moral nihilism implicit in Sigmund Freud's theoretical structure, rather than primarily from a rejection of the theory itself.

³ *New Ways in Psychoanalysis* (W. W. Norton & Co., N.Y., 1939, 313 pp.), pp. 75-76. Fromm's position remains more theoretically consistent. In *Escape from Freedom* (Farrar & Rinehart, Inc., N.Y., 1941, ix and 305 pp.) institutional authority as developed in a historical framework is designated as the cause of both neurosis and "normal escapes" in modern western culture;

Two things are being attempted in this paper: first, by a brief discussion of the socialization process taking place in a specific Polish-industrial community to demonstrate the inadequacy of a clinical etiology of neurosis in terms of either love-thwarting or the arbitrary exercise of authority; second, to explain in sociological terms the context in which "lack of genuine love" and "authority" operate to produce neurotic symptoms.

I

Sinclair Lewis failed to "see" Sauk Center until he had spent some time at Yale and in New York. Similarly, to evaluate what parts the "lack of genuine love" and "arbitrary authority" in themselves play in the etiology of neurosis a comparison should be made of their effects in different contexts.¹

The author spent his childhood and young adulthood in a Massachusetts industrial village of some three thousand population, most of which is made up of immigrant Poles and their native-born children. It was previously pointed out how the middle-class norms governing courtship and marriage do not apply within this local Polish colony.² This is also true of parent-child relationships.

The local Polish parents emigrated before marriage from farm villages and small towns in Poland. While the old familistic tradition has been slowly deteriorating in rural Poland for several decades, enough of that tradition was brought with them so that their expectations of their American-born children's conduct reflected an alien peasant system of values.

An outstanding feature of peasant family life, in contradistinction to that of modern middle-class family organization, is the stress placed upon rules and work-functions rather than personal sentiments for the *individual* etiology of neurosis and "pathological normalcy." Fromm points to the experience of irrational authority in the family of orientation: see "Individual and Social Origins of Neurosis," *Amer. Sociol. Rev.* (1944) 9:380-384 (No. 19 in this volume).

¹ This seems to conform to Robert M. MacIver's dictum: "... any effective causal enquiry should be addressed to a specific difference between comparable situations." Page 85 of *Social Causation* (Ginn & Co., 1942, x and 414 pp.) The question might be raised that "comparable situations" are not being dealt with here, but both Fromm and Horney use "the family" and "the modern family" as generic terms, without differentiation according to class, ethnic group, etc.

² Arnold W. Green, "The 'Cult of Personality' and Sexual Relations," *Psychiatry* (1941) 4:343-348.

ment; and parental authority is excessive by the standards of any comparable segment of the American population.⁶ These rules of conduct and this parental authority are out of place in the American industrial slum. Second-generation Poles participate in a social world outside the home which their parents, because of language difficulties and previous conditioning, are incapable of sharing or even of understanding. As bewildered parents attempt to enforce old-world standards they are met with the anger and ridicule of their children. In answer to this, the parents have final recourse to a kind of authority which was unsanctioned in Poland: a vengeful, personal, irrational authority, which no longer finds support in the future hopes and ambitions of the children; and this new authority is no longer controlled by both parents' families and a cohesive community. But this personal authority will not suffice to curb their wayward progeny, who have little respect for their parents as persons, and who soon come to learn that their "American" playmates are not subjected to anything like it in their homes.

It is through this tragically antagonistic, mutually distrustful clash of wills that the relations of parents and children tend to be lacking in "love" (which is alien to the peasant *mores* anyway). At the same time, there is plenty of "irrational authority." In exasperation and fear of losing all control over their Americanized youngsters, parents apply the fist and whip rather indiscriminately. The sounds of blows, screams, howls, vexatious wails of torment and

⁶ "In all the relations between parents and children the familial organization leaves no place for merely personal affection. Certainly this affection exists, but it cannot express itself in socially sanctioned acts. The behavior of the parents toward the children and the contrary must be determined exclusively by their situations as family members, not by individual merits or preferences." (W. I. Thomas and Florian Znaniecki, *The Polish Peasant in Europe and America* (Knopf, N.Y.: 1927, Vol. 1, p. 94). In other words, parental authority, while usually unleavened with "love," is based not so much on personal caprice (Fromm's "irrational authority") but mutual respect for common rules of behavior and labor functions within the household unit.

Respect, not love, is the tie that binds in the peasant family. And within a rigid set of rules, parental authority is almost absolute: "... a rebellious child finds nowhere any help, not even in the younger generation, for every member of the family will side with the child's parents if he considers them right, and everyone will feel the familial will behind him and will play the part of a representative of the group" (*Ibid.*, Vol. 1, pp. 91-92). If the male child's will is considered, it is not because of respect for his individual personality, but because of the increasing power and control the child will assume; he will finally assume the father's place as head of the household.

hatred are so commonplace along the rows of dilapidated mill-houses that the passerby pays them scant attention.

*But those children do not become neurotic.*⁷ Why? Because parental authority, however harsh and brutal, is, in a sense, casual and external to the "core of the self." The Polish parents do not have the techniques and opportunity to *absorb the personality* of the child. In the first place, the child has many models of behavior to adopt both within the family (five to eight children are, in estimate, modal in the Polish section of the village) and outside. Siblings present a more or less united front in their rebellion against their parents. Parent-avoidance techniques are easily acquired be-

⁷ The author is no psychiatrist, and the reader may wonder at the foolhardiness of making such a statement. Yet in the overt behavior of an entire generation in the village, whom the author has intimately known as children, adolescents, and young adults, there was no expression of anxiety, guilt-feelings, rigidity of response, repressed hostility, and so on, the various symptoms described by Horney as characteristic of the basic neurotic character structure. It is impossible to check directly on the reasons for rejection at the local induction center, yet a Polish informant has assured me there is no known case of army rejection because of psychoneurosis within the local Polish community.

Of course, the argument might be raised that only a psychiatrist could discover the unconscious personality conflicts which were present. There is no adequate answer to this charge, just as there is no adequate answer to the orthodox Freudian's charge that only a Freudian can criticize classical psychoanalysis because only a Freudian can understand it. Admittedly, this is no water-tight rebuttal; about all that can be said here is that the total description of the socialization process taking place in the local Polish community at least leaves open the door to the possibility that many who experienced it did not become neurotic. And it is pertinent to remember that analysts have knowledge of only upper middle-class and upper-class behavior.

According to Horney the neurotic develops one of three trends, or some combination of them: masochistic (making the self small and insignificant), narcissistic (appearing unduly significant to one's self and insatiably craving admiration from others) and perfectionistic (need for others' recognition of the self's infallibility, particularly moral infallibility). These trends are all accessible to direct observation within a field of personal interaction, without psychoanalytic techniques. The only personality-trend in these Polish youngsters which resembles any of Horney's formulations is the narcissistic; it is not so much "neurotic," however, as sheer crass egocentrism. According to middle-class standards the socialization process has simply been left uncompleted, with but an elementary self- and social-awareness resulting. And it is *because* these youngsters remain egocentric, with little identification of self with others, that they are spared such neurotic symptoms as anxiety and guilt-feelings. This does not mean they are never unhappy and miserable; far from it, but these feeling-states have nothing in common with the neurotic trends and symptoms described by psychoanalysts, which are all dependent upon intensive identification.

cause of the parents' halting use of English and the fact that both parents, typically, work in the local factory, leaving the younger children to the daytime supervision of older children, which frequently results in no supervision at all. The open woods and fields are close at hand and the children roam far. The homes are not particularly clean, nor do they contain bric-a-brac or furniture of any value, so that the local Polish child is spared the endless admonitions which bedevil the middle-class child not to touch this or that.

The children also develop a tolerant or openly malicious contempt for their parents as stupid, unknowing of American ways, concerning which the children regard themselves authorities. By and large, the parents are obstacles to be avoided, or circumvented wherever possible. And while the resulting lack of identification with the parents virtually obviates demonstrations of affection, it also saves the children from feelings of guilt and repressed hostility.⁸ The training of the child becomes, then, casual, haphazard,

⁸ Demonstrations of affection are not altogether lacking, but they have little in common with the definitions of parent-child love found in the middle-class women's magazines. A fairly common positive attitude is a fleeting, rather grimly humorous appreciation of the other's alleged shortcomings. On occasions where an expression of sentiment would seem to be appropriate, such as a funeral within the family, parents and children are clumsy, awkward, embarrassed with one another. Too many avenues of approach have been sealed off in the past. Relations with parents tend to improve as the children become economically independent; while extremely rare, it does happen occasionally that a father and his grown son may be observed drinking beer together at one of the tables in the Polish Club. It must be remembered that while the local Polish community is an industrial slum, it is also a rural community, and there is sufficient cohesiveness within it to enforce at least the outward appearance of intra-family solidarity; this is not experienced to any great degree, however, until the children reach young adulthood, and only if they take up residence within the community.

No claim is being made that the early training of all Polish youth in this community is exactly alike, nor that the attitudes of parents and children toward one another are exactly duplicated from family to family. It is here that the "subjective element" in insight (where the observer himself constructs patterns of behavior, at least in part, or merely interprets field-conjuncture?) and in the participant-observer technique becomes potentially dangerous: a single description of a behavior-type or development is applied to various individual personalities, families, situations. And so, in the local Polish community, there is the boy who cripples his father in a fist-fight, runs away from home never to return; another lad, married and raising a family of his own, wistfully wishes he "had gotten to know the old folks better." One girl leaves home at sixteen to become a prostitute; another delays marriage to care for an

"free" in a sense, very similar to the training received in many primitive tribes, except for the negative other-regarding attitude of parent and child so typical in the village.

II

The claim has been made that "lack of love" and "irrational authority" do not, in and of themselves, cause the development of neurotic symptoms. These phenomena do operate, however, in individual etiologies of neurosis, but only within a certain context. The term "personality absorption" has already been used. Personality absorption is the physical and emotional blanketing of the child, bringing about a slavish dependence upon the parents. It is personality absorption, in conjunction with factors other than lack of love or irrational authority, that produces a certain type of neurosis.

To delineate the kind of socialization which maximizes personality absorption, it will be necessary to conceive of a parental type which simultaneously occupies several population segments: native-white, Protestant urban, college-educated, middle-class.⁹ The training of children born to parents who can thus be characterized, is so experientially consistent it has a certain range of predictive value.

ailing mother. Thus reality, compressed into a single formulation, become distorted.

This is not the place for justification of abstraction. I am convinced, however, that if another observer could spend many years in the village, and find some means of participating in the life of a large number of families representing all groups, as did the author, he would agree that the training of any second-generation Polish child would deviate but slightly from the above general description, while the training of any lower middle-class Protestant child would deviate from that description to a marked degree.

⁹ The problem here is defining "middle class" in such a way as to maximize psychological relevance. Robert S. Lynd has defined middle class as that class which is off the economic floor (objective) and conceives of itself as going places (subjective). For present purposes this can be revised as follows: the middle class is that class whose members have welded their attitudes and value into a life-long striving toward an improvement of personal socio-economic position within the class-structure. By this definition the lower class then becomes made up of those who acquiesce to inferior status and the upper class those with an assured superior status. The only "objective criterion" which can be admitted in conjunction with the foregoing definition of middle class is that a given person not be permanently blocked in his striving by reason of race, color, ethnic-group, which are essentially caste elements.

Now, how can we define the middle-class child's situation? ¹⁰ It has already been said that his personality is "absorbed," ¹¹ and to the extent that it has been absorbed, he is in danger of developing neurotic symptoms. But why is it absorbed?

Perhaps the best way to view his social conditioning is to consider his parents, and their position in relation to him. ¹² The father's work takes him far from the place of residence, where most of his associates are only slightly less strangers to him than they are to his family. He is a white-collar worker. As a salesman, office worker, minor bureaucrat, or professional man, his job-techniques revolve around manipulating the personalities of others, instead of tools. Since he has internalized the supreme middle-class value, individual success, he tries to use his associates as means to further his career; in fact, he has himself been conditioned to view his associates, education, hobbies, intellectual interests, in terms of their possible value to his career. ¹³ On the job he views himself not so much as functionally associated with others in a common purpose, as a self-contained unit establishing "contacts" with others. His work relations are not defined in fixed terms of status and role to the extent that they were in the past for he is on the move, or views himself in that way. He has, then, a well-developed tendency to view his relations with others *in terms of what he, as a mobile, displaced person, can get out of them.*

Yet the modern middle-class father cannot use his *child* either in

¹⁰ Not only has "middle class" been loosely defined, but also the claim is not being made that all middle-class children are equally affected by the ideal-type conditioning described, which is a deliberate exaggeration of the factor-conjunction which maximizes personality-absorption. In individual cases there will be different combinations of the factors enumerated, as well as deviations from individual factors.

¹¹ Fromm's formulation of the "pseudo self" must not be confused with "personality absorption." Fromm views the self as having a dynamism of its own, apart from its social context: the pseudo self arises when the self accepts the ideas, values, and goals of others as its own. The present author accepts no such demarcation of self and social: the self is derived within the given social context; personality absorption occurs when that context is narrowed for the child to include little more than one or two adults.

¹² Peculiarly enough, parents are viewed either as constant factors or as the villains in the piece in most discussions of "individual factors" in neurosis. But it is rather important to find out what there is to being a modern middle-class parent that fertilizes the soil of the child's neurosis, however, the individual seed may be planted. It will not suffice to dismiss the matter with "the parents' own neuroses," as does Horney.

¹³ See Arnold W. Green, "Duplicity," *Psychiatry* (1943) 6:411-424.

the new sense of manipulating others to his own advantage, nor, be it noted, in the ways available in the past. In the old rural-familistic system, the child served well three predominant interests of the father: he would soon work on the farm, or during the earlier days of the industrial revolution, in the factory, become an economic asset to the father; in other words, he would provide economic security in the father's old age;¹⁴ and finally, he would provide psychological security by preserving the family name, a form of this-worldly immortality in a society which made the family the primary repository of most social values.

In terms of dollars alone, the cost of raising a modern middle-class child represents a serious threat to the personal ambition of the father.¹⁵ At the very time when, in terms of his primary success-goal, he should have time and money available for further study if a professional man, money for clothes, entertaining, household furniture and an automobile for purposes of presenting a "front" in any event; at this time when his career is in its initial and hence its crucial stage, the presence of the child represents a diversion of energy and funds, so long, of course, as the career remains his primary goal. A certain degree of ambivalence directed toward the child is inevitable. Not the depth, but the present height of the middle-class birth-rate is the noteworthy phenomenon, indicating an amazing vitality of the old rural-familistic values which find little support in modern social structure.

With the advancing individuation of modern society, not only has individual success become a supreme value, but also individual, hedonistic enjoyment. The child again presents an interference with most of the recreation available to the middle-class father, for whether commercialized (movies, sports events, plays) or social (golf, bridge, tennis, dinner parties), these are designed not for

¹⁴ This obligation, as an individual experience, is fast passing. See Robert M. Dinkel, "Attitudes of Children Toward Supporting Aged Parents," *Amer. Sociol. Rev.* (1944) 9:370-379. The government bureaus are planning old-age assistance benefits on the assumption that an increasing proportion of the aged will fail to secure support from their children. See W. S. Woytinsky, *Labor in the United States* (Social Science Research Council, Washington, 1938, xxii and 333 pp.).

¹⁵ Basing their estimates on a family income of \$2,500, Dublin and Lorka figure that the parents spend between \$9,180 and \$10,485 in rearing a child through the age of 18. (Quoted in Kingsley Davis, "Reproductive Institutions and the Pressure for Population," *Sociological Rev.* (1937) 29:1-18—a British publication).

family-wide participation, but individual- or couple-participation.

In conjunction with the above factors, the growing middle-class emphasis upon "scientific child care"¹⁶ and the child's higher education, further increase the father's duties and obligations, while his rights steadily diminish. What emerges from his total situation is an ambivalence toward his child which is more or less widespread, though very rarely admitted, even with confidantes.¹⁷ Finally, children interfere with the companion and partner roles of husband and wife, which are more and more displacing the traditional patriarchal and housewife-and-mother roles.¹⁸

And how about the mother? She enters marriage and perhaps bears a child with no definite role and series of functions, as formerly. Her old role within the patriarchal family, with its many functions, its economic and emotional security, its round of community participations, is lost, but no well-defined role has taken its place. She feels inferior to men because comparatively she has been and is more restricted.¹⁹ If she works after marriage she faces sex discrimination on the job and perhaps her husband's criticism if his traditional role of bread-winner is important to him.

Half-seriously she prepared for a career prior to marriage, half-seriously because a career is regarded by most middle-class girls as insurance against the grim possibility they will not be

¹⁶ The child must not be spanked, parents should be "patient" with him, his ego-growth must not be curbed, etc. The assumption of much of the child-care literature seems to be that the parents have a combined culinary, nursing, and psychiatric function, and nothing more. But note that in a mobile, industrial, specialized job-world, with its emphasis upon contractual relations, that cooks, nurses, and psychiatrists are paid for what they do.

¹⁷ It would be impossible to ascertain directly the extent of this ambivalence. Asking a man whether or not he approves of the Bretton Woods Proposal differs from asking him whether he loves his little daughter—to be indicated on a ten-point scale. It differs, first, because Bretton Woods is relatively extraneous to the core of the self and is publicly defined as something upon which one may express a wide divergence of opinion, and, second, because a man's attitude toward his daughter is made up of a series of personal experiences, some delightful, others not, all complicated by a cultural compulsive to repress consciousness of ambivalence toward one's own children. Recall George Babbitt: of course he *loved* his wife, Myra, and sometimes he almost liked her!

¹⁸ See Willard Waller, *The Family* (Cordon, N.Y., 1938, 621 pp.)

¹⁹ The extent of the actual emancipation of women has been commonly exaggerated. Within all classes in our culture, as in all other cultures, women are trained to regard themselves as inferior to men in some degree. It is usually desired that the first child shall be a boy, by wife as well as husband.

married; through a "good" marriage (the folk phrase "she married well" refers not to personality adjustment but to the bank balance and career prospects of the husband) the middle-class girl attains far more status than is possible through a career of her own. But the period of phantasy dalliance with a career, or an embarkation upon one, leave her ill-fitted for the drudgery of housecleaning, diapers, and the preparation of meals. The freedom which the urban apartment and modern household devices have brought the middle-class housewife has been commonly misinterpreted as well as exaggerated. While the Victorian housewife had more work to do, that work was part of a well-integrated system of household and community activities. While the modern middle-class housewife has more leisure-time than either her mother or grandmother, she must still work at a number of household jobs for which she has not been trained, which are usually not an essential part of her value-system, and which are isolated from her social activities. One sociologist has expressed this dilemma facetiously: half her working day is spent doing something she does not like, the rest is spent thinking up ways of getting even with her husband. The resulting boredom frequently leads to a period of indecision early in the marriage over whether to have children or resume the career. This internal conflict has been well-expressed by Thompson:

In the present economic situation in the United States increase of population is not desired. The fact that small families are the rule is one of the factors driving women out of the home. Now that they are not in the home a kind of vicious circle is formed, for it is no longer convenient to be occupied in the home by one or two children. Much conflict centers here, for it is one of the problems of the culture which as yet has no generally satisfactory solution. Individual women have worked out ways of having both children and a career, but most women still do one or the other; and in either case there are regrets and often neurotic discontent . . . the problem is not solved by going to the other extreme and trying to prove one's adequacy by having a child or two. The women of past generations had no choice but to bear children. Since their lives were organized around this concept of duty, they seldom became aware of dislike of the situation. . . . Nowadays, when women have a choice, the illusion is to the effect that unwanted children are less common, but women still from neurotic compulsion bear children they cannot love.²⁰

²⁰ Clara Thompson, "The Role of Women in This Culture," *Psychiatry* (1941) 4: 1-8, p. 6.

And so it is inevitable that the child shall be viewed with some degree of ambivalence by both father and mother, for he represents a direct interference with most of the dominant values and compulsions of the modern middle class: career, social and economic success, hedonistic enjoyment. There is some doubt that *under modern middle-class conditions*, children automatically bring husband and wife closer together.²¹

To return to the consideration of the middle-class child. Personality absorption takes place against a background of parental ambivalence. The mother has little to do, in or out of the home; she is her single child's sole companion.²² Modern "scientific child care" enforces a constant supervision and diffused worrying over the child's health, eating spinach, and ego-development; this is complicated by the fact that much energy is spent forcing early walking, toilet-training, talking, because in an intensively competitive milieu middle-class parents from the day of birth on are constantly comparing their own child's development with that of the neighbors' children. The child must also be constantly guarded from the danger of contacting various electrical gadgets and from kicking valuable furniture. The middle-class child's discovery that the living-room furniture is more important to his mother than

²¹ See Ernest W. Burgess and Leonard S. Cottrell, Jr., *Predicting Success or Failure in Marriage* (Prentice-Hall, Inc., N.Y., 1939, xxiii and 472 pp.), esp. page 413. In their sample they found a slight negative correlation between number of children and self-rating of marital adjustment. Lewis M. Terman, *et. al.*, *Psychological Factors in Marital Happiness* (McGraw-Hill, N.Y., 1938, xiv and 474 pp.) apparently remain unaware that their characterization of "Happily married women," derived from statistical manipulations, is a classic statement of the middle-class Victorian housewife-and-mother role. If "happiness" for married women must be something founded in a fading tradition the future looks black. Fortunately, Terman and associates have probably not established isolable unit-factors; instead, sifted elements out of a total middle-class cultural setting which is rapidly changing, *i.e.*, their "factors" may not be applicable in the immediate future.

²² The addition of one more child, which is the outside limit in most middle-class homes, probably does nothing to diminish the possibility of the first child's developing a neurosis if there is an appreciable gap in their ages, because of the likelihood of sibling rivalry. See David M. Levy, *Maternal Overprotection* (Columbia University Press, N.Y., 1943, ix and 417 pp.). Levy's valuable monograph has not been used in the present discussion because Levy conceives of the overprotective mother as a person who has voluntarily renounced the world and all its works to devote her entire life to the sacred cause of her own child; the "middle-class mother" is here conceived as a type which has not resolved a conflict between "duty" and individualism. The latter is much more common.

his impulse to crawl over it, unquestionably finds a place in the background of the etiology of a certain type of neurosis, however absurd it may appear.

Under constant supervision, with limited play-area in a house touching other homes on all sides, or in an apartment, and lacking companions, the child's physiological expansiveness, fed by his boredom, persists in getting him into trouble: screaming, running around the apartment, upsetting daddy's shaving mug, rending teddy-bear in two, emptying his milk on the rug to observe what pattern will be formed. This "trouble" is all a matter of definition. Similar behavior, in modified form, would not be interpreted in primitive society as "trouble," and neither would it be by Polish parents in the community above described.

Already the parents have made "love" of supreme importance in their relation to the child, theirs for him and his for them, partly because of the love-complex of our time, which is particularly ramified within the middle class,²³ and partly as a compensation for the many sacrifices they have made for the child, long debated before and after its arrival. *The child's need for love is experienced precisely because he has been conditioned to need it.* That the need is biological seems unlikely.²⁴ Now, the more ambivalent the

²³ Children are being more and more regarded by young middle-class couples as a symbol of *romantic* consummation. "And soon we'll be three," the popular song goes; the child is, then, considered more in terms of being a product of wedded egos than of having an integral place of his own in a family unit. Also, as parents no longer secure economic good and security from children, the affectional element is stepped up to give the parents a reason for having children. In fact, William F. Ogburn has made affection his only hope for preserving our present family form.

²⁴ Margarethe Ribble, in "Disorganizing Factors of Infant Personality," *American Journal of Psychiatry* (1941) 98:459-463; says: "There is a necessity for a long and uninterrupted period of consistent and skillful 'psychological mothering' by one individual. This must continue at least until speech is well-developed and the child has acquired a feeling of self-security and voluntary control of his body equilibrium. . . . It seems that the tone of the gastrointestinal tract in this early period depends in some special way on reflex stimulation from the periphery. Thus the touch of the mother has a definite, biological implication in the regulation of the breathing and nutritive functions of the child" (Page 463). Two things should be noted here: while a certain amount of handling during infancy by one person may be necessary, that person need not be the biological mother; and it would be difficult to measure the extent of the need.

There are several excellent empirical studies of the socialization process now available and in all of them a great deal is made of the child's need for love and

parents are toward the child, the more seriously is the "trouble" he causes them interpreted. He should not act in such a way because of the sacrifices they have made in his behalf, and the least he can do is show his gratitude by "loving" them in turn, *i.e.*, keeping out of "trouble." When the trouble inevitably occurs, *the most effective punishment imaginable is the threat to withdraw their love from him.* He "needs" that love because his personality has been absorbed by these two persons, because he has been conditioned to have a slavish-emotional dependence upon them. *Not the need for parental love, but the constant threat of its withdrawal after the child has been conditioned to the need, lies at the root of the most characteristic modern neurosis.* Mamma won't like you if you don't eat your spinach, or stop dribbling your milk, or get down from that davenport. To the extent that a child's personality has been absorbed, he will be thrown into a panic by this sort of treatment and develop guilt-feelings to help prevent himself from getting into further trouble. In such a child a disapproving glance may produce more terror than a twenty-minute lashing in little Stanislaus Wojcik.

The threat of love-withdrawal is usually the mother's technique for controlling the child. At first the father may threaten to withdraw love, but as the child grows older the father finds a more subtle control—the expression of disapproval. The child is limited to his parents for modelling his behavior. While very young, he wants to set the table and sweep the floor "like mummy." In a few years standards of manly conduct are imposed and he wants affection. But in every single instance studied the child had either been early conditioned to regard love as the most important thing in the world, or had had the opportunity of observing other youngsters receiving something which he did not have. This is not to deny that some affirmation of personal ties to others in primary-group relationships, if not a biological need, is at least universal, but it is doubtful that it need be the type of parent-child love discussed in such studies. Primitive children, brought up in large dwelling-units among many kinsmen, in a sense spread thin their affection over a wide area, and this affection is relatively less in total intensity as well. Polish children, in the village above described, receive short shrift from their mothers when they begin to walk, and even during infancy there is little dandling and cooing, in fact, after weaning, the child is most frequently literally handed over to the eldest daughter who gives the child the strictest minimum of attention. Among the siblings there is little demonstrativeness: there is, however, the fierce loyalty of an in-group on the defensive; this loyalty comprises the principal matrix for the imposition of the actual moral code by which they live. Describing "genuine love" *in and of itself* as a necessity for preventing neurosis is sociologically naive.

to do things "like daddy." The father now controls him through the child's new self-conception, and it is not so much the use of "authority" as threatening the child's self-respect.²⁵ The child is not a person who amounts to very much, how does he ever expect to get along when he gets old enough to go to school, or join the Boy Scouts, or go to college, or get a job? Again, to the extent that the child's personality has been absorbed, he will be made to feel small, insignificant, unworthy. And, feeling absorbed, caught and helpless, must propitiate these combined god-monsters that he needs so desperately. Hence anxiety, guilt-feelings, the sense of inferiority; seek security at all costs for he is living alone and afraid, in a world he never made.²⁶

As for authority, its exercise generates neurotic symptoms only under two conditions, both of which must be present; close identification of the child with at least one parent; the effective blocking-off of all avenues of authority-avoidance for twenty-four hours of the day. Neither of these conditions is met in the Polish homes described, and thus while the authority wielded by Polish parents is far more "irrational" (as defined by Fromm) than that likely to be encountered in many middle-class homes, neuroses are not developed. Indeed, it seems unlikely that Fromm's differentiation between rational and irrational authority has much psychological relevance. The *child* is hardly in a position to understand when authority is ". . . based on the competency of the person in authority to function properly with respect to the task of guidance he has to perform . . ." ²⁷ and when it is ". . . based on the power

²⁵ I am immeasurably indebted to Dr. Franklin J. Shaw, for long stimulating conversations about his work at the University of New Hampshire Psychological Clinic. He states that male students seeking psychotherapy invariably recall ridicule and ego-attacks by the father during the period of first testing male roles.

As for the "authority" formulation, is it not possible that it may be subsumed under "love withdrawal"? From the child's point of view, even corporal punishment becomes unbearable primarily because it represents the father's withdrawal of love and support. During adolescence, authority as such does become a problem for the child, but the "normal" child suffers from it then as much, and oftentimes more, than does the neurotic.

²⁶ All middle-class children certainly do not become neurotic. But to the extent that their experience approaches the polar type described, they will tend to. This picture is often exaggerated by the parents' own unacknowledged hostile impulses toward the child, stemming from the individualistic values and strivings described.

²⁷ Erich Fromm, "Individual and Social Origins of Neurosis," *American Sociological Review* (1944) 9:380-384; page 381. (No. 19 in this volume.)

which the authority has over those subjected to it and on the fear and awe with which the latter reciprocate."²⁸ Perhaps the Polish children do not experience irrational authority exactly as defined by Fromm, for while they fear parental authority they also are hostile toward and contemptuous of their parents, and thus are not in awe of them. Nevertheless, the important differentiation is not between rational and irrational authority but the extent to which any parental authority succeeds in absorbing the child's personality, *which is itself dependent upon factors other than the imposition of arbitrary authority.*

Yet when we have used the term "personality absorption" we have not by any means explained a neurosis etiology. The personality of the middle-class girl of the late nineteenth century was "absorbed" by her parents, she was subjected to the demands of "love" and unquestioning obedience, at least ideally; nevertheless, the rate of neurosis under those conditions was probably not too high, as nearly as can be judged at this later date. Why? Because she was not faced with inconsistent expectations of conduct on the part of others and herself. Because love and obedience were integrated within a role which changed relatively slightly from childhood into adolescence, courtship, and finally into marriage. In other words, her initial goals and self-conceptions were constantly re-enforced with each new life experience.

The modern middle-class child on the other hand, particularly the boy, who has found surcease from anxiety and guilt by blind obedience and "love" for his parents, is not allowed to stabilize his relationships with others on that basis. His play-group, which may be denied him until he has reached school age, makes him feel a certain shame and inadequacy in attempting to approach its members with familiar techniques.²⁹ He also early discovers that he is involved in competition with others, as an individual with his contemporaries, and as a representative of his family unit with other families.

If the abstraction "ours is a competitive society" is translated into terms of what happens to the child born to modern middle-

²⁸ *Ibid.*, loc. cit.

²⁹ The play-group has immeasurable sociological significance for it is secondary in importance only to the family of orientation in the socialization process. Unfortunately, the only good empirical studies of the play-group available are of institutionalized children or slum children whose gang behavior is regarded as a social problem.

class parents, it becomes quite relevant to the present discussion. Before the child has developed a real self-awareness he becomes part of a process of invidious comparison with other families: he uttered his first word two months earlier than the Jones' boy; he weighed so many pounds at the end of his first year. At Sunday School he received the Bible for perfect attendance; at public school his grades in arithmetic were higher than two-thirds of the other members of the class. He may take piano lessons in view of the day when Mrs. Smythe's pupils will be on public exhibition before the parents of the neighborhood. Everything he accomplishes or fails to accomplish becomes an inevitable part of the family's attempt to maintain or improve its standing in the community.

But effective competition demands a certain degree of independence, firmness of purpose, perhaps aggressiveness. Even for the "normal" middle-class child the transition from submission to some degree of independent behavior is made difficult.³⁰ And for the child whose personality has been absorbed, an especially exacerbated conflict arises. He is expected to "do things," to accomplish, perhaps to lead in some endeavor, like other children, but his earliest social conditioning was dependence, submission, inferiority; his accomplishments, if any, are on a god-scale—in phantasy. He is desperately attempting to stabilize all later relationships on the basis of his earliest conditioning. Any pressure to compete only exaggerates his anxiety guilt, and feelings of inadequacy. Life in the modern middle-class home insures that he shall feel that pressure.

There are, then, three elements in the etiology of what has been called the most characteristic neurosis of modern society; personality absorption; the reiterated threat to withdraw a love which has been made of paramount importance; a conflict between the resulting initial adjustment of submissive propitiation and the later assumption of goals of achievement and roles of independent action.

The child is not able to establish an integrated self-conception.

³⁰ See Ruth Benedict, "Continuities and Discontinuities in Cultural Conditioning," *Psychiatry* (1938) 1:161-167. On page 161 appears this statement:

"From a comparative point of view our culture goes to great extremes in emphasizing contrasts between the child and the adult. The child is sexless, the adult estimates his virility by his sexual activities; the child must be protected from the ugly facts of life, the adult must meet them without psychic catastrophe; the child must obey, the adult must command this obedience."

Propitiation has meant obedience and "love" for the parents, leading to a compulsive repression of self-will. But he soon discovers that propitiation, in the sense of meeting new parental expectancies, means exhibiting independence, self-assertiveness, aggressiveness, *outside* the home. The father, as the child's mediator of the outside male world, rather than the mother, makes this demand uncompromisingly which may, incidentally, be one of the unsuspected sources of the so-called oedipus complex. This seems more than likely since male neurotics often recall facing the father's ridicule of their first fumbling efforts to meet the father's expectations of "manly" conduct.

With the new conflicting expectations, on the part of parents and contemporaries, the child's anxiety reaches new heights, a *double set of guilt-feelings appear where previously there was only one*: at first he felt guilty only if he failed to love and obey, and this guilt could be assuaged by the propitiation of submission; now, however, the god-monsters will be appeased only by a combination of submission in his role of child-in-family, and assertiveness in his play-group, school-pupil, and other roles enacted outside of home. An integration of these conflicting roles is impossible. His conception of himself becomes one of abject failure. Any striving is painful for it violates the initial submissive adjustment. But he feels equally guilty for not making the effort to achieve. This is a key to much of his contradictory and self-blocking behavior: his desire to be the last man in the last regiment and his desire to conquer the world; his demand that everyone shall love him, and his settled conviction that no one could love a person as base as he; his inability to erect a hierarchy of values; his endless debate over the value of his own goals. He is damned if he does and damned if he doesn't. He is embraced by a psychological Iron Maiden: any lunge forward or backward only impales him more securely on the spikes.

TWENTY-FOUR

The Human Life Cycle and Its Interruptions—a Psychologic Hypothesis¹

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A REVIEW of the literature will lead the student of later maturity to discover 2 general tendencies, one of method, the other of attitude: (1) an effort to understand the whole of man through isolated criteria and (2) a tendency to regard adulthood as a more or less continuous state of maturity terminated by progressive decline and death.

An individual at any time in his life is the aggregate and interaction of many functions, some in development, some at peak, and some in decline. Any approach toward comprehending the nature of man that uses for measurement a single function, or even a group of functions, such as sensory acuity, motor response, intelligence, vocabulary, etc., succeeds in describing merely a dissected part of a totality. A society such as ours, which appears to place a heavy emphasis on the attributes of youthfulness, physical agility, and the behavioral constellation surrounding reproduction, makes the same error on a cultural scale that the researcher makes on a

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laboratory scale, i.e., it fails to integrate enough human variables into a realistic life scheme, and views human growth with lopsided values, so that adult life is popularly regarded as the simple achievement of an ambiguous maturity followed by a general decline.

Shakespeare's cynical 7 ages of man (Table 1) parallel fairly closely the popular notion. The contributions of recent investigators, notably summed up by such authors as Gumpert, Stieglitz, and Erikson, who find evidence for further personality growth in later adulthood, have not yet received sufficient attention.

This paper is an introductory effort to organize some observations and tentative conclusions made on the basis of psychiatric clinical experience with several hundred older patients of many diagnostic categories in and out of a mental hospital, and to develop methods and some criteria for testing the hypothesis that has evolved and is to be described.

BACKGROUND FOR A THEORY

A point of view regarding stages of maturation requires an analysis and resynthesis of the factors playing a part in personality organization. For simplicity these may be separated into 3 general groups: biologic, physiologic, and psychosocial. Focusing attention on one area yields unilateral conclusions.

Biologists have long considered the adult stage of all living organisms as the period of procreation and parenthood. Since the primary function of all living things that will have been achieved by reproduction and subsequent life for the adult will be an *anticlimactic* outliving of usefulness, it follows that after rearing of the young the most logical sequential step must be termination of individual existence.

The physiologic investigators with an apparent biologic orientation seem to have been bent on finding means for sustaining juvenescence, keeping alive sexual-reproductive interest, and thus postponing individual terminus as they view it.

Little place is found in a mobile and aggressive society, except fortuitously, for individuals in the postreproductive phases of life. The popular and scientific concepts of *climacterium* and *involution* that relegate postclimacteric existence to an ignominious level in the pattern of civilization have been stultifying and restrictive. The absence of an adequate conceptual scheme, meager informa-

TABLE 1. STAGES OF MATURATION *

Shakespeare ("As You Like It")	Erikson ("Childhood and Society")		Present Hypothesis	Evolence
"At first the infant mewling and puking in the nurse's arms."	Oral	Trust vs. mistrust	Instinctual supremacy	
	Sensory			
?	Muscular	Autonomy vs. shame, doubt	Education of the in- stincts	
	Anal			
?	Locomotor	Initiative vs. guilt		
	Genital			
"And then the whin- ing schoolboy, with his satchel and shin- ing morning face, creeping like snail, un- willingly to school."	Latency	Industry vs. inferiority	Social learning	
?	Puberty	Identity vs. role diffusion	Instinctual supremacy	
	and adolescence		Pairing	
"Then a soldier, full of strange oaths and bearded like the pard, jealous in honour, sudden and quick in quarrel, seeking the bubble reputation even in the cannon's mouth."	Young adulthood	Intimacy vs. isolation	Mating and reproduc- tion	Senescence
?	Adulthood	Generativity vs. stagnation	Family creative	
			Social creative	
?"	Maturity	Integrity vs. disgust, despair	Instinctual supremacy (involution)	
			State creative	
"And then the jus- tice in fair round belly with good ca- pon lined, with eyes severe and beard of formal cut, full of wise saws and mod- ern instances."			Moral and ethical re- affirmative	
			Retrospective evalua- tive	

Shakespeare ("As You Like It")	Erikson ("Childhood and Society")	Present Hypothesis
"The sixth age shifts into the lean and slipper'd pantaloons, with spectacle on nose and pouch on side. His youthful hose, well saved, a world too wide for his shrunk shank; and his big manly voice, turning again toward childish treble, pipes and whistles in his sound."		Social unlearning (Senile latency)
"Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans every- thing."		De-education of in- stincts
		Instinct supremacy

Senility

* Comparing and contrasting Shakespeare's poetic sardonicism with psychiatric and sociologic points of view. The popular bard's opinion, probably reflecting cultural attitudes, shows heavy E values and disdain for later maturity.

tion, and perhaps a lack of interest and attention have hampered a changing view.

The authors are of the conviction that the human life span is in fact a predetermined, inexorable cycle in which genetic and instinctual endowments are the motivators. The beginning and end points of this cycle are not birth and involution but conception and death.

The biologic dogma is applicable, probably, to most other forms of life in the animal kingdom, but seems singularly untrue in the human animal: An innate endowment for social organization in animals is very likely the genetic conveyance of the results of eons of trial-and-error adaptation, but from generation to generation their societies are relatively immutable. While animals do appear to have societal organization and do appear to have cultures, it is in the transmission of these cultures that a difference is perceived

between man and animal. Some ancient prompting deep in the genetic development of the animal guides his activities, whereas the human culture is transmitted postnatally quite specifically to each individual and by elders as a rule. The human culture is so complex that the transmission process requires extensive recording systems with the attendant complexities necessary to maintain the communication network. On this basic difference between animal and human societies depends much of the relative difference in the function of the aging human being and the aging animal. The aging human individual is just beginning some of his most important functions when parenthood ceases.

STRUCTURE OF A HOLISTIC CONCEPTUAL FRAMEWORK

The approach of no single scientific discipline is sufficient to account for the behavior of the complete organism. Every step in behavioral progression is dependent on biologic diatheses, physiologic preparation, psychologic integration, and social demands. Man in action is the composite of these basic factors and his behavior is their expression. A study of observable behavior ought to disclose the functions of a total organization at any stage in progression.

It may well be that the additional function of the adult of preserving culture, of maintaining the annals of history, of keeping alive human judgment, of maintaining human skills, of preserving and skillfully contriving the instruments of civilization, and of conveying all this to oncoming generations, is the postreproductive work of the human organism and that this realistic and valuable quality of the human mind is uncovered or manifested in the senescent individual.

The authors are not unaware of the numerous arguments that are stimulated by a hypothesis of this type. It may be pointed out that the function of cultural maintenance is not unknown to the earlier stages of human development, and that procreativity does not preclude socially oriented thought and cultural precept. Obviously, these and related arguments must be accepted, but they do not refute the hypothesis. Personality development is a continuum. Factors present in fractional quantities in early periods of growth become preponderances in later stages, while the reverse is also true.

•The initial observation giving rise to this theoretic formulation

is that there appears to exist the same kind of conflict in the shift at middle life that exists during the adolescent shift. Traditionally, the youth at adolescence is rebellious. Under the pressures of pubertal change he seeks independence, self-expression, and freedom of action. The pronouncements of his elders, usually parents, are rejected out of hand as outworn solutions not applicable to himself.

We see a striking recurrence of this internecine strife at middle life. For convenience let us divide the life cycle into halves and let us name the young side of the middle of life as *evolescence*,¹ with the older side *senescence*. We may now speak of the "E's" and the "S's." We can perceive the rebellion of the E's against the S's. Some of this rebellion is the frustration that comes in recognizing the older wisdom, a recognition of the irreality of one's own wishes. Some of it comes from within. The individual perceives his own metamorphosis from an E to an S. He fights the change because our society has placed all its values in *evolescence* and has not voiced or even recognized the more subtle inherent values in *senescence*.

The S counter-rebellion is a continuous restatement of old ideals, a tenacious attachment to the established and proven solutions, a reluctance to countenance social revolution, and an increasing awareness of the value of the past as a predictor of the future and an instrument of judgment.

The S segment of life, rather than being a merely tolerated period before the organism's demise, is very likely a socially necessary phase following the mid-area in the human life cycle and continuing until the individual ceases to exist or until destructive processes supervene. It is probable that the psychophysiologic events that characterize involution are less significant as the termination of the reproductive function and are more important as preparation of the individual for subsequent social functioning.

Personality may be regarded as a series of peak achievements, and for every faculty that passes its prime a further developing faculty becomes dominant that has yet to reach its level of highest integration. Thus the conclusion is reached that adult life is not one continuous plateau of maturation, but is a series of merging stages, regarded for convenience as early, middle, and late and their subdivisions (Fig. 1). For the sake of clarity a definition of maturity is necessary at this juncture.

¹ Derived from Latin, *ex volvere*, meaning to *unroll*, to *roll out*, and Latin, *alascere*, meaning to *grow*.

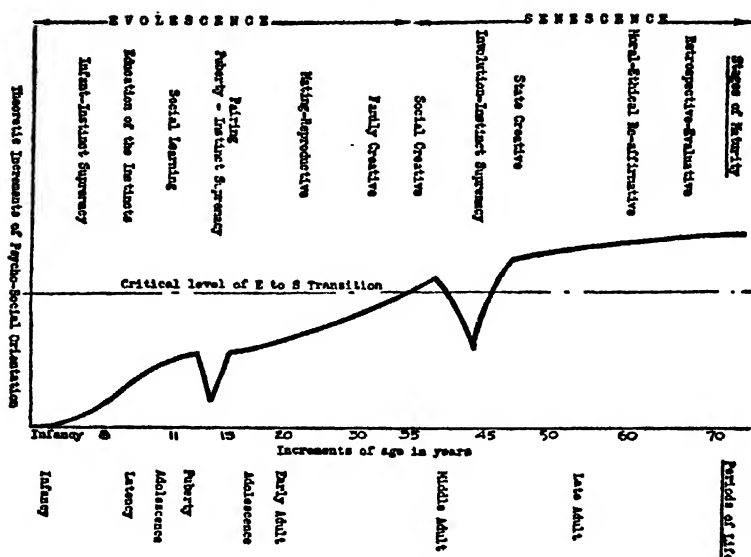


FIG. 1.—The development of social vision in the human life cycle.

THE MATURITY CONCEPT

The comprehension of maturity as a level of psychologic development is too involved an area of study for a brief account. However, a thread of consistency is found to run through all efforts to understand it. The common denominator of varying points of view regarding maturity is *integrated environmental orientation*.

The freshly conceived organism lacks maturity, but it does possess unbridled forces in its infantile state. What is to become of these forces, or how they are to be expressed as the organism goes forward is determined in large part by counterforces that derive both from an internal environment, the psyche, and an external environment, reality. Counterforces are obstacles. The presentation of an obstacle yields conflict. Solution of conflict is experience. The integration of experience is organization. The most efficient organization is maturity. *Maturity, therefore, is the achievement of efficiently organized psychic growth predicated upon the in-*

tegration of experiences of solving environmentally stimulated conflicts.

Most of the demands upon forces within the individual are made by the external environment. (This can still be regarded as true when the external environment is internalized.) Since the most potent environment is the society in which he lives, it is seen that an individual's conflicts are in the main socially incurred. Thus, a concept of maturity requires the realization of a psychosocial organization, or what may be termed *cultural direction*. This means that the individual is understood largely through his ways of relating to and comparing with the group, its experiences, and its mores.

The essential difference between evolescence and senescence is to be found in the cultural direction of conflict solution. The E portion of the life cycle begins as nearly complete dependence and is characterized by progressive private rebellion against dependence. Dependence is mainly upon the S culture against which the E bid for independence is expressed as egocentric strivings for gratification of instinct-urges, or pleasure-seeking, regardless of its manifold disguises.

It is axiomatic that the union of groups of no matter what dimensions depends upon the intensity of *sharing of conflict solution* by the participants. Since pleasure-seeking is private and selfish, it is probable that the E state of cultural direction is negative to some degree and tends toward group fragmentation. This would eventuate in cultural disintegration were it not for the S culture with its public orientation, which tends to contain and to restrain individual instinct-pleasure seeking.

The S viewpoint causes many E strivings to be regarded as dangerous, because if fulfilled they threaten group integration. It is therefore seen that *the S attitude is simultaneously directed toward protection of the E's against social perils and toward the preservation of a culture.*

The development of his civilization and the maintenance of its culture are probably man's loftiest ideal. Such an ideal is of the widest possible social scope and requires for its realization the progressive renunciation of E egocentricity and the development of S protectiveness and altruism. It is therefore hypothesized that the attainment in the individual of S functioning despite its many modalities represents the achievement of a broad cultural vista. Contrary to popular views holding that older people are more re-

stricted in their psychic interests, this study suggests their general outlook is actually broader and less selfish than that of younger, or less mature, people.

STAGES OF MATURATION

The definition of psychic maturity given earlier suggests that the process of maturation may be measured as a resultant of 2 vectors: selfish (instinct-gratifying) drives and culture-directed (protective and altruistic) drives obtaining at any point along the life course (Fig. 1).

Infancy starts as a period of instinct-supremacy and is followed by a series of relationships between the infant-child and his environment, producing experiences that have been called "*the education of the instincts*." The renunciation and alteration of instinctual drives lead to further social learning in the child as he attempts to achieve a progressive mastery over his own impulses and orients his new-found ambitions toward accomplishments in reality. This increase in cultural orientation that characterizes earliest adolescence is interrupted by bio-physiologic puberty. The psychologic effect of puberty is a resurgence of temporarily concealed drives, a regression toward instinct-supremacy. The process of coping successfully with such insistent energies leads to further personality organization in adolescence with the emergence first of *self-identity* and later rudimentary parental attitudes. This proceeds into *pairing*, a psychologic device that allows for the mutual working out of problems of identification and develops attitudes relating to the smallest possible social unit—a group of 2 people of opposite sexes.

The capacity for intimacy growing out of adolescent pairing and the egocentric psychologic attitudes directed toward the fulfillment of pleasure urges culminate in the *mating and reproduction* of early adulthood. A later phase of early adulthood is then characterized by the beginnings of larger group formations. This may be termed a *family creative* period. The psychosocial organization at this level is relatively small, constricted, and confined to the development of the home-family unit.

Middle adulthood, or middle maturity, then appears as a stage of widening social interest in which the family-society becomes increasingly oriented within the framework of its responsibility

toward a greater society. This may be termed a *social creative* period. It is during this period that the progeny are traversing earlier phases of evolescence and in which parental attention is directed toward assisting in the integration of offspring wishes with social requirements. Clinical experience gives the impression that people at this phase of maturation are concerned with the social development of the family and the community collective of families.

The involutorial disturbance (cf. below "The Interruptions") is self-limited and is followed by personality reintegration with the advent of the third or late phase of maturity.

Later maturity appears to be roughly divided into 3 sequential segments. The predominant mature point of view in the first segment may be regarded as a *social-political* one, or *culture-organizational*. By this time of maturity the progeny have reached an early adult phase and are themselves in a family creative period. A ruling and protective sovereignty befalls the mature adult at this level as he assumes the parental hierarchical leadership over his family of families. Thus, the scope of interest here becomes wider and is concerned with the creation, ordering, and maintenance of a larger society, or what may be called the state. Thus, in a sense, the first segment of late adulthood may be called *state creative*.

The second segment of late maturity is ushered in by a set of conditions requiring the establishment of social, moral, and ethical standards. It may be said that at this regulative level in the life cycle it is necessary for the establishment of pacific relationships among the oncoming generations that the parental ruling body draw upon cumulative experience to render decisions, assist in planning, erect social guideposts, and to select subordinate leaders. The judgmental functions of the human mind may be found to be most highly developed during this period. Judgment is created out of actual and vicarious experience with conflict solutions and out of cultural learning. Since cultural standards are established, archetypical, and have withstood the tests of historical application, the necessity for judgmental functioning produces a kind of rediscovery of old values already found effective in cultural maintenance. For this reason, the second segment of late maturity may be called a *moral and ethical reaffirmative* period.

The integration of the mature personality at this level yields a profound concern for system, order, and meaning in human

existence and engenders an almost newly found kinship with past (parental) leaders and regard for the current standard-bearers of all the disciplines of culture (technologic, scientific, etc.).

The need to correlate the present with the past to determine the true nature of accomplishments, errors, and rediscoveries ushers in the last phase of late psychic maturity. The area of cultural vision at this level is at its broadest possible development (Fig. 2) embracing one nearly complete life cycle and its interrelatedness with a multitude of other life cycles throughout its span of existence. The individual at this level compares and contrasts his

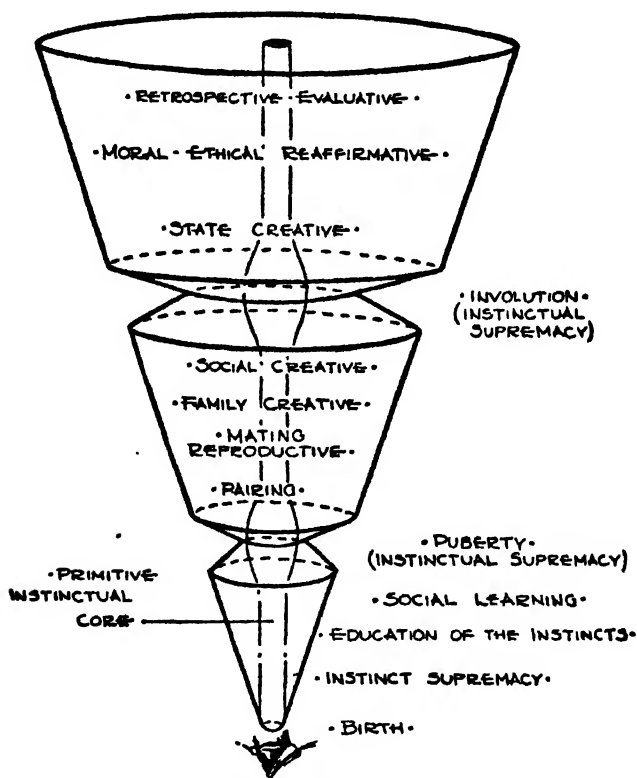


FIG. 2.—Psychosocial orientation. This is a schematic representation of the breadth of psychosocial vision among the course of the human life cycle. Places of narrowing area are periods of instinct supremacy associated with biophysiologic upheaval.

values with cultural values to which he has been longitudinally exposed, and through a process of conscious reasoning and intuition he evaluates meaning and purpose. Intuition is probably unconscious statistical analysis of experience. Hence, this latest period becomes one of *retrospective examination*, and an increased interest in the history of human development may be found at this level.

It may be said that whereas the early evolescent views himself as a potential ambitious and dauntless master of a dimly conceived mankind, the late mature senescent, by contrast, views himself with real humility as at most a contributor or at least a participant in the improvement of his society.

THE INTERRUPTIONS

Any period of physiologic upheaval, whether in the form of illness or a stage in growth, eventuates in a psychic disturbance. Emotional defenses elaborated by the individual to handle ordinary living events of the preceding period are excessively taxed during such stages of transition as puberty and involution. A variable amount of loss or diminution of defense-effectiveness occurs with a concomitant threatened break-through of hitherto submerged instinctual and infantile emotional patterns. The need to deal with this internal threatened weakening of psychic structure causes much available mental energy to be concentrated toward an effort to create new bulwarks and repair old ones. Thus, external environmental interest is withdrawn and is internally directed as self-interest. As a consequence, psychologic growth is held in abeyance either until the physiologic storm subsides or until better defenses regain dominance.

A PLACE FOR SENILITY

It is the common clinical experience with late senescents to find evidence of a psychologic reactive state just prior to the onset of the senile condition. They speak readily of feelings of lowered self-esteem, a diminution of self-confidence, and an increased sense of insecurity. Further investigation almost invariably reveals that they have suffered sociodynamic factors of rejection, exclusion, setting aside, isolation, and neglect. Clinical work with such people yields a high order of improvement on a complete program of environmental manipulation, interested care, and psychotherapy, individual

or group. Where the therapies are not applied or are unsuccessful, organic deterioration follows and proceeds to dementia and to death.

It is probable that the third interruption to psychic maturation postulated by many investigators is a social illusion. The authors conclude that *senility as an isolable state is largely a cultural artifact and that senile organic deterioration may be consequent upon attitudinal alterations.*

The latter hypothesis is difficult to prove and lends itself to much argument. It is based upon the concept of psychosomatic unity and the realization that the loss or impairment of psychic defenses (resistances) is related simultaneously to a similar impairment of physical resistances. An unbroken cycle ensues unless strong external forces are applied to reinstate psychic structure. Successful therapeutic programs appear to impede the organic breakdown.

CULTURE AND SENILITY

A precise American cultural attitude toward the aged is not easily discerned. Our elders seem neither devotedly revered nor yet unceremoniously excluded. Perhaps our attitude may be described as an amused tolerance and a legally imposed but grudging acceptance.

A partial answer to the question of how such an attitude develops is found in the E-S conflict discussed earlier. In addition there may be evidence that ours is an E-dominated culture. It is probably the nature of the egocentric state that its own values are overdetermined. Among the E-values in our culture that may be overdetermined are movement, agility, quantitative productivity, exhibitionistic sexual attractiveness, and artfulness. S-maturity contrasts strikingly with its greater emphasis on deliberation, caution, quality, modesty, and loyalty.

Since the S individuals represent loss of youth, diminution of physical power and stand as supporters of cultural code, advocates of wisdom, and reminders of death, they are scorned by the E's. This disdain for age is implanted in the early E mind as a latent attitude.

The obvious conclusion, therefore, is that as an evolescent progresses into senescence his own latent attitudes toward S are revived and are directed against himself. In other words, in a

culture that emphasizes E values the S person expects to be rejected and rejects himself.²

STAGES OF SENILITY

When criteria of perceptible behavior and expressed fantasies are evaluated and analyzed, it may be found that actual senility consists of a series of declinations of behavior. The onset is replete with instinct-dominated affects and ideation. This condition of psychic frailty is followed by a period of reparation with return of better social functioning. The term, *senile latency*, may apply here (Fig. 3).

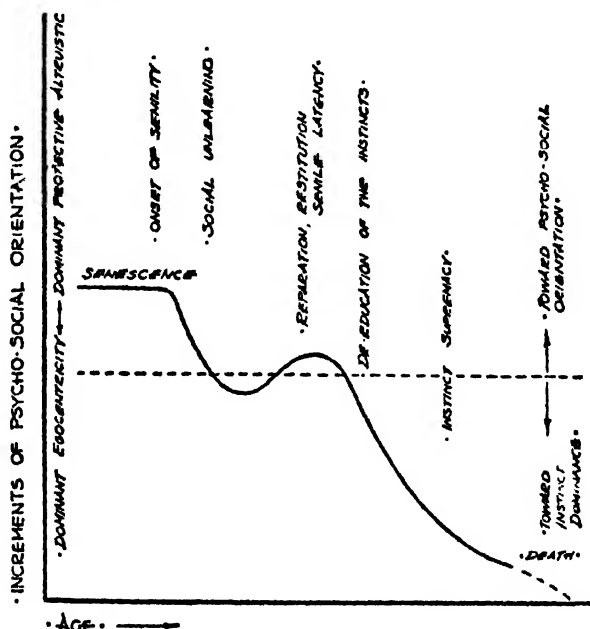


FIG. 3.—Senility. Stages of senile retrogression. This is a magnified continuation of FIG. 1.

² If the viewpoint presented here has some degree of validity, then a careful study of elder-venerating cultures (such as the Chinese) should disclose less "senility" among their aged in contrast with elder-discarding cultures.

The partially restored psyche, however, fails to endure without environmental assistance and often despite it, so that a further breakdown follows and progresses. The entire process suggests *social unlearning* and what may be called *de-education of the instincts* appears. Each gain in psychosexual evolution and social maturation made in evocescence is progressively dissipated in reverse order—the latest acquired being the first lost. Thus, language expression progressively deteriorates through stages of decreasing comprehensibility to gibberish and nonverbal communication. An early upthrust of adultlike sexual appetite gives way to masturbatory and perverse orificial sensuality with progressive loss of sphincter mastery and associated fantasies. Partially controlled aggressiveness yields to impulsiveness and acting-out, moving toward wantonness and, finally, toward subsultus. This is accompanied by increased motor incoordination, enfeeblement, and waning of proprioception with inability to maintain erect posture. Affects change toward a privately enjoyed irritable euphoria. Orientation, related to apperceptive and cognitive functions, regresses to complete withdrawal of interest and comprehension from temporal and spatial relationships. Memory loses its acuity for the present, becomes hyperacute for the remote past, and finally dwindles into near-nothingness. Food tolerance is altered by stages from solids to pap and milk. Exitus is the natural outcome.

The entire picture is one of progressive loss of self-direction toward abject dependency and instinct supreniacy. When these stages are evaluated, it may be seen that they resemble, with very little difference, the period *birth-to-puberty in reverse*.

PSYCHOPATHOLOGY AND THE STAGES OF MATURATION

The hypothesis as outlined here presents real and ideal stages of maturation relating to a theoretic personality norm. It is clear that certain of the neuroses are by their very nature immaturity reactions or early E attitudes persevering beyond their archaic origin. Such E viewpoints preserve egocentricity and interfere to some degree with the achievement of S maturity. However, non-neurotic personality elements are subject to progressive maturation. It may be said that the more neurosis warps, hinders, or alters ego development then the less will psychosocial maturation be realized.

This is, of course, true also whether the individual is single or married, barren or fertile. However, if it is assumed that the rearing of a family presents a greater number of experiences of this particular quality, then it follows that a potentially greater degree of S maturation is possible where child-raising is part of the life cycle. But the psyche preoccupied with stress may be rendered nonreceptive to experiential integration. Parenthood obviously does not guarantee maturity and childlessness may be accompanied by considerable maturation. Still, in the latter, a qualitative difference is perceived that militates against complete maturation.

This can be better understood by consideration of another hypothetical probability. Every stage in the organism's physical development is biologically motivated. Since the psyche is a somatic function, physical maturation implies a simultaneous simple psychic ongoing maturation also based on biologic impetus. The psychic function of awareness is directed toward the self and the external milieu. Thus a biologic diathesis for psychosocial maturation may be thought of as endowed in the organism. However, this is merely a primitive groundwork upon which experiential maturation takes place.

The psychoses follow to a certain extent the hypothetical laws pertaining to the neuroses, *i.e.*, latent conflicts out of E antiquity interfere longitudinally with psychic maturation. Psychosis may be regarded as the loss or impairment of environmental awareness and of defense-effectiveness with the break-through into perceptible behavior of symbolized latent conflicts. The conflicts leading to psychosis are derived from inadequately solved early E problems, but as they rise toward consciousness and expression their symbolization is influenced by the personality's most recently acquired psychosocial orientation and is colored as to content to some degree by the dominant attitudinal set characteristic of the achieved stage of maturation.

SUMMARY OF THE HYPOTHESIS WITH RESEARCH POTENTIALITIES

The attention of scientists to date has focused on those elements in a life that come to their fullest expression prior to middle age, and are on the wane when middle life is reached. This unbalanced concentration supported by public instruments of communication

has provided a distorted view of life as a cycle ending near the middle with the second half a barren interlude preceding one's demise.

This hypothesis predicates a middle-life interruption at or around involution, ending a period called *evolescence* and ushering in a period rich both in actuality and potential called *senescence*. It reserves the term *senility* for a psychopathologic entity frequently occurring in late senescence, which should not be confused with the normal predemise deteriorative state.

With involution as an interruption similar to puberty and with senescence as an unexplored period following involution, much research suggests itself. As is necessary in most research, a descriptive stage is needed here. We need to know the dimensions of senescence not only in terms of the skills and behavior already measured in evolescence, but we need to identify the social creative and other attributes that are only beginning in evolescence and reach full maturity in the senescent period. We might well do for senescence what Gesell and Amatruda have done for infancy and childhood; *i.e.*, construct a set of development scales by which to look at senescence. Where Gesell has concentrated on physical growth, the student of senescence would concentrate on social growth and social patterns of behavior.

This would offer us new dimensions for the study of intraindividual and interindividual conflict. It is our belief that much intraindividual conflict is conflict of (a) an individual's chronological age, (b) his expectations of himself, and (c) the expectations that others have of him. In a society venerating the values of evolescence or even in its early stage of adolescence, the man entering the later years can but pursue the chimera that the adolescent value represents for him. Measures available to determine his orientation might well serve as a diagnostic tool for his release.

Similar tools could well serve as the measure of interpersonal conflict. Within the family certain unexplained elements of human emotions may find solution through such measures. For example, there is the inference that in a given family the greater the disparity in ages between the E-level offspring and the S-level parent, the greater the difference in psychosocial vision and, hence, the greater the conflict.³ In addition, it is suggestive that the closer the E's and

³ The protectiveness and altruism of S maturity are not to be confused with the overprotectiveness and excessive interest sometimes directed toward grandchildren by grandparents. This latter relationship is very likely a symp-

S's are in chronology, the greater the mutuality in conflict solution. What is often interpreted as passivity may be altruistic protectiveness attributable to S maturity.

The hypothesis offers a theoretic index of maturation that, if tenable, permits categorization of individuals along a scale of psychosocial achievement. Any considerable difference in a given individual between his testable index level and the expected may be of diagnostic importance, and goal establishment in psychotherapy may be thus facilitated. An index of maturation implies the needs of an individual at a given stage in his development. Thus, his emotional and social requirements, his talents and capacities, and his occupational potential may be managed realistically.

A second area of research related to the first is the delineation and clarification of senility as a pathological process, as opposed to the longer period of which it is but the final rapid stage, senescence. In an era when older men and women are being dubbed "senile" when they may be acting as older men and women act, this is a serious social problem (see Table 1). If, on the other hand, senility has already begun, it is our belief that research in therapy is both necessary and possible to provide knowledge whereby senility may be deflected from its otherwise inexorable course.

The knowledge of stages of senility may not only assist in prognosis but may also aid in fitting therapy to the peculiarities of the senile condition. For example, the enormous dependency needs and self-isolation of the senile respond remarkably to an independence-fostering program engineered in an integrated group setting. In a large number of such people, physical and psychic decline can be arrested or slowed. This is not designed so much for the purpose of extending longevity as it is to help promote some degree of serenity during the remaining period of life.

There is abundant evidence that the life span is increasing and that our population is aging. The need to employ usefully the added years of creative capacity accruing to people requires study, evaluation, and recognition of the stages of maturation of the complete life cycle.

Once we have descriptive dimensions of senescence with measuring instruments comparable to those available at other stages of the life cycle, and once we can separate age normalcy from age pathology, we can turn our research tools to questions at every tomatic and symbolic phenomenon representing hostile, dependent, and restitutive attitudes in the threatened ego.

stage within senescence and to the borders of senescence and evolescence.

Good descriptive criteria can be used to reflect different medical care programs, recreation, housing, and employment programs in terms of their most pertinent factors—factors that relate to senescence and that find their furthest development and have the greatest pertinence to this period of life.

The Psychology of the Negro under Discrimination *

HORACE R. CAYTON

THE NEGRO in the United States is an oppressed minority. This oppression, based in some sections of the country on law, is further reinforced by tradition and custom. It finds its final sanction in the application of force and violence. It is a little difficult for us to think of the Negro as an oppressed people. Such terms as minority group, caste, second class citizens, etc., are more to our liking. But the hard fact is that the Negro is oppressed and his oppression finds its ultimate sanction in force.

Richard Wright, and I will make frequent reference to his work as he has written more profoundly on this subject than any other American student of the question, has described the Negro's position in this country in the following passage from his novel, *Native Son*:

If only ten or twenty Negroes had been put into slavery, we could call it injustice, but there were hundreds of thousands of them throughout the country.

If this state of affairs had lasted for two or three years we could say that it was injustice; but it lasted for more than 200 years. Injustice that lasts for three long centuries and which exists among millions of people over thousands of square miles of territory, is injustice no longer; it is an accomplished fact of life. . . .

What is happening today is not injustice, but oppression. . . .¹

What are the instruments of this oppression?

A recent study of lynching has presented that phenomenon in

* From "The Psychological Approach to Race Relations," *Reed College Bulletin*, 25 (November, 1946), 8-27. This excerpt from a longer paper is reprinted by permission of the author and the publisher.

¹ *Native Son*, by Richard Wright, Harper and Brothers, 1940, p. 329. By permission of the publishers.

a new light—as a method of social control.² The study outlines the various phases through which a community goes in performing this collective act. The first phase is the growing fear that Negroes are beginning to make too many demands, are getting out of hand, are getting out of their place. Next there is a muttering among the white citizens that something should be done about it. After the white community has been alerted to the so-called danger, an incident is seized upon which can be used as a justification for punishing the entire black community. Then a lynching occurs and, it is important to note, it is not always necessary to lynch a particular Negro—often any Negro may do. On the pretense of avenging the alleged crime the white community intimidates, cows, and often wreaks great physical damage to the person and property of numbers of colored people. During the lynching Negroes disappear from the streets and hide in their own communities. Afterwards they reappear silent, hesitant, avoiding as much as possible contact with white people. Finally, when it becomes apparent that no more punishment will be administered, the Negro population attempts to ingratiate itself by obsequious behavior; smiling, laughing, and in other ways trying to show the white people that they have accepted their punishment with good grace. This is the fear that accompanies a lynching. It is a fear that no Negro will ever forget. It is a fear upon which the entire system of social control in the South is ultimately based.

But how, one might ask, even if that fear characterizes the people of the South, would people in Northern cities such as New York, Chicago, Detroit, and Cleveland be affected by it? My hypothesis is that Negroes are so conditioned by this and other forms of violence (and their defenselessness before such terror) that there has developed in the group what has been called an oppression phobia.³ . . . The collective experience of the Negro people has been such that even when they are in the North they fear the violence which they or their parents experienced in Mississippi.

It is difficult, without this concept, to explain why, in a state which has a civil rights law, an eminent Negro lawyer, perhaps even one employed by the Court, will shamefacedly leave a restaurant when told by a slip of an illiterate white waitress that he will

² "Lynching and the Status Quo," by Oliver C. Cox, *Journal of Negro Education*, Fall number, 1945, Vol. XIV, No. 4, p. 576.

³ Editor's note: the wording has been changed slightly from the original at the request of the author.

not be served. The law is on his side. He knows that cases have been won on such issues. He may be, as I have indicated, an officer of the Court itself. But the fear he experienced in Mississippi when a Negro was burned alive for talking back to a white girl store clerk dissolves his manhood. Too, it is not only his danger but the fear that his behavior will endanger all Negroes. The individual, in deciding whether he will perform an aggressive act, must determine whether his group will support him and whether he can face the isolation from the group if he does not receive such support. Because of the oppression phobia, a group feeling of fear and terror, in many cases he knows that he will not get such support; the other members of his group are suffering from the same fear that bedevils him. He is not afraid of just a rebuff or a refusal, but is motivated in his behavior by the collective group feeling of irrational fear and insecurity.

Fear and insecurity of the parents is transmitted to the child long before he realizes that he is a Negro and what that implies in our culture. Thus, through the parents the children are conditioned from birth to feelings of insecurity and fear and are not given the protection and security which they as children need.⁴ In an article reviewing the book *Black Boy*, by Richard Wright, I used the title "Frightened Children of Frightened Parents," which, it seems to me, describes this psychological mechanism.⁵

The adult Negro is in all of his dealings with white men either consciously or unconsciously in a state of tension. To protect himself from his fears he has devised a mask which he assumes in the presence of all white persons. Toward any member of his group who acts aggressively, or who drops the mask of humility in the presence of whites, the Negro as a group is very ambivalent. The group condemns the aggressive person for fear that his act may

⁴ Richard Wright, in his book *Black Boy*, describes his feeling as a young Negro raised in the Deep South: "Tension would set in at the mere mention of whites and a vast complex of emotions, involving the whole of my personality, would be aroused. It was as though I was continuously reacting to the threat of some natural force whose hostile behavior could not be predicted. I had never in my life been abused by whites, but I had already become as conditioned to their existence as though I had been the victim of a thousand lynchings." (From *Black Boy*, by Richard Wright, Harper and Brothers, 1943, p. 65. By permission of the publishers.)

⁵ "Frightened Children of Frightened Parents." *Twice A Year*, edited by Dorothy Norman, Double Number XII-XIII, Spring-Summer, 1945, and Fall-Winter, 1945.

bring reprisals to all, but the "bad nigger" who flaunts white society is also eulogized in folk songs and fables.

Thus the Negro, in a subtle sense, is at war with his environment. There is a close analogy between Negroes living in America and a soldier under battle conditions. We are just beginning to learn about the terrifying effects of fear on human personality. Fear on the battle field which is in conflict with the soldier's ideals of patriotism and courage, may cause the personality to regress and ultimately to collapse. This subject has been the field of study for many scientists during this past year.⁴ Many of the findings of these students can now be applied to other situations in civilian life where men exist under great stress, tension and fear. This is certainly true of the quality of the Negro's experience in America, and perhaps these findings may give some insight into the tremendous emotional price which the Negro pays for living in this country.

The comparison of the soldier under battle conditions with the psychology of the American Negro was first made in literature. The writings of Richard Wright, for example, indicate the extent to which this sensitive artist has been able to observe these psychic phenomena. Again and again Wright has pointed out the similarity between these two experiences in living. . . .

Because of the oppression phobia arising out of the Negro's fear for himself and for his group, the feelings of a Negro worker taking a new job in a plant antagonistic to Negroes, or of a Negro attempting to be served in a white restaurant, are often similar emotional experiences to that of the soldier. But the Negro has had to learn, like the war-hardened veteran, to adapt himself to fear in order to survive. He has developed, because of this constant presence of fear, a sort of immunity to it. If a white person were suddenly put into the position of the American Negro with no preparation or conditioning experience, he would undoubtedly, as many soldiers have under battle conditions, be paralyzed with anxiety. . . .

I recall a trip I made in the Deep South with a famous sociologist and his wife. We rode on that trip as conspirators in an enemy country. Each meal presented itself as a challenge, a battle to be fought, and each success was greeted by us as a victory over the

⁴ "The Combat Neurosis," by S. Kirson Weinberg, *The American Journal of Sociology*, March, 1946, Vol. LI, No. 5, p. 465. Also *Men Under Stress* by Roy R. Grinker and John P. Spiegel, The Blakiston Company, 1945.

enemy. As lunch time grew near we were all silent with a tension which descended over the entire car. Would we, under some pretext, be able to eat together? If not, could I find a Negro restaurant? If there were no Negro restaurants, should I go to the kitchen of the white hotel and pretend to be their chauffeur or should I remain in the car and have them bring sandwiches to me? At night came the question of finding a place to sleep. Should I again pretend to be their servant and attempt to get servant quarters at the hotel? Could I find a Negro family who might have a clean guest room? Should I sleep in the car or should we all travel on, in spite of fatigue, until we could find a city where I could obtain lodging?

Even normal body functions presented a problem. They could be performed, to quote Belden, "only with considerable opposition, delay, annoyance and irritation." Could I drink from the water fountain at the filling station? Would there be provisions for washing my hands or face? If a toilet was not marked "white" or "colored," dare I use it?

Every mile of the road we encountered difficulties, hindrances, and frictions which bothered, annoyed, and infuriated. All of these impeded our progress and upon all we expended energy which detracted from our pleasure and exhausted us physically and emotionally. Added to this friction was of course the fear which arose out of both the real danger and the irrational over-evaluation of possible danger in the environment. As a Negro, in performing the simple act of living, I found myself irritated by the frictions set up against me, endangered by real possibilities of harm, and the target of all of those barbs, indignities, heartaches, and the thousand shocks that black flesh is heir to.

Some notion of the irritations as well as the daily lynchings of the soul which Negroes endure are illustrated in an incident from a novel entitled *If He Hollers Let Him Go* by Chester B. Himes. [There is] . . . a scene in which a young Negro man takes his girl to a downtown hotel in Los Angeles for a meal. The writer describes with disturbing realism the emotions of these two tortured and frightened persons who were engaged in the simple act of eating out—an act which white Americans would consider a break from humdrum family life, but which became for these persons a nightmare of tension, torture, and humiliation. . . .

Now let us analyze a little more closely the dynamics of the oppression phobia. I am convinced that at the core of the Negro's

mentality there is a fear-hate-fear complex. My assumption is that all men in Western European civilization have unconscious guilt and the fear of punishment for this guilt. In the case of the dominant group this guilt is to a large extent irrational. It can be shown to be false, a figment of the imagination, a hold-over from early childhood experiences. It can usually be resolved by treatment by the psychiatrist or even by rational cogitation. But in the Negro the psychological problem is intensified. For him, punishment in the actual environment is ever present; violence, psychological and physical, leaps at him from every side. The personality is brutalized by an unfriendly environment. This reinforces and intensifies the normal insecurity he feels as a person living in our highly complex society. Such attacks on his personality lead to resentment and hatred of the white man. However, the certain knowledge that he will be punished if his emotions are discovered produces a feeling of guilt for having such emotions. Fear leads to hate; but the personality recoils with an intensified and compound fear. This is his reaction to his own brutalization, subordination, and hurt. It is this vicious cycle in which the American Negro is caught and in which his personality is pulverized by an ever mounting, self-propelling rocket of emotional conflict. The Negro has been hurt; he knows it. He wants to strike back, but he must not—there is evidence everywhere that to do so would lead to his destruction.

Dr. Helen V. McLean has described this complex in the following quotation:

Fear is probably the predominating feeling of any persecuted minority toward the strong dominating group. . . . The final character of the Negro may be a protesting, fighting Bigger [the hero of *Native Son*] or a passive, submissive figure like Bigger's mother, but at the core of the personality with either extreme of character reaction lie fear and hatred of the white man who has humiliated and frustrated him.⁷

We can find such extremes in character development in any Negro community. But few attempts have been made to document them by social scientists. In literature, however, there are two excellent examples. Again I would like to refer to the enraged hero of the book *If He Hollers Let Him Go*, for an analysis of his character reactions gives us insight into the emotional difficulties many Negroes are presented with.

⁷ "Race Prejudice," by Dr. Helen V. McLean, *The American Journal of Orthopsychiatry*, Vol. XIV, No. 4, October, 1944, p. 711.

Robert Jones, a young Negro from Cleveland, went to the West Coast to make big money during the war boom. He was in love with a beautiful colored girl superior to him in social position. A great deal of his conflict arose out of the fact that this girl whom he loved tried to persuade him to accept her more passive, submissive role in relation to whites which would bring him, she believed, the rewards of white society. He was emotionally incapable, however, of mastering his rage at the humiliations which white society thrust upon him.

Jones had not always been in such a rage about the injustices he endured. When he left Cleveland he said, "Race was a handicap, sure, I reasoned. But, hell, I didn't have to marry it." But in the boom city of Los Angeles where living was crowded and the tempo of life accentuated to a hysterical pitch; where a migrant warring population of Negro and white southerners met in the expanding war industries, he began to feel the extreme tensions of race hatred. "I could always feel race trouble, serious trouble, never more than two feet off. Nobody bothered me. Nobody said a word. But I tensed every moment to spring."

The impact of world events, too, had their effect on his consciousness. In trying to account for his hysterical rebellion against injustice and humiliation he said, "Maybe it wasn't until I had seen them send the Japanese away that I noticed it. Little Riko Oyama, singing 'God Bless America' and going to Santa Anita with his parents the next day.

"It was taking a man up by the roots and locking him up without a chance.

"Without a trial. Without a charge. Without even giving him a chance to say a word. I was thinking about if they ever did that to me."

Jones' tension on being thrown into contact with white men was excruciatingly painful. He was a frightened man. He was afraid of white people. He said, "I felt that sick, gone feeling again. I began trembling; I felt sick, scared. I knew I could take it; but I was scared of what I might do. Scared of what might happen to me afterwards. If I could just stop thinking; every time I thought of trouble I thought of death."

Jones was afraid that his hatred of white people could be detected. (The final fear of the fear-hate-fear complex.) His girl asked him, "If white people hated you as much as you hate them . . ."

"They'd kill me now and have it done with," he replied, "and that would be fine with me."⁸

This driven, impulse-ridden, frightened personality developed under the dynamics of the fear-hate-fear complex, a sort of cornered rat psychology. He was afraid of whites. He hated whites. He was afraid of his hate of whites. He was afraid of his unconscious desire to be passive to whites and to give up what appeared to be a hopeless struggle.

At the opposite pole of personality reaction to Robert Jones is a character named Shorty described in Richard Wright's *Black Boy*. Shorty was intelligent. He had hopes for his race and wanted to advance himself. But he lived in the Deep South where such ambitions were looked upon almost as acts of rebellion. His impulses to play a manly role in the community and to have hopes and aspirations for the advancement of his people came in sharp conflict with his passivity. These contradictory sets of values developed in him a feeling of guilt and a need of punishment for that guilt. From time to time when his anxiety mounted to a pitch that he could no longer control it or the tension it engendered he would relieve himself of his anxiety by a low, obscene mechanism. Wright describes this man in the following passage:

The most colorful of the Negro boys on the job was Shorty, the round, yellow, fat elevator operator. He had tiny, beady eyes that looked out between rolls of flesh with a hard but humorous stare. He had the complexion of a Chinese, a short forehead, and three chins. Psychologically he was the most amazing specimen of the southern Negro I had ever met. Hardheaded, sensible, a reader of magazines and books, he was proud of his race and indignant about its wrongs. But in the presence of whites he would play the role of a clown of the most debased and degraded type. One day he needed twenty-five cents to buy his lunch.

"Just watch me get a quarter from the first white man I see," he told me as I stood in the elevator that morning.

A white man who worked in the building stepped into the elevator and waited to be lifted to his floor.

Shorty sang in a low mumble, smiling, rolling his eyes, looking at the white man roguishly.

"I'm hungry, Mister White Man. I need a quarter for lunch."

The white man ignored him. Shorty, his hands on the controls of the elevator, sang again:

⁸ Chester B. Himes, *If He Hollers Let Him Go*, Doubleday and Co., Inc., 1946. By permission of the author.

"I ain't gonna move this damned old elevator till I get a quarter, Mister White Man."

"The hell with you, Shorty," the white man said, ignoring him and chewing on his black cigar.

"I'm hungry, Mister White Man. I'm dying for a quarter," Shorty sang, drooling, drawling, humming his words.

"If you don't take me to my floor, you will die," the white man said, smiling a little for the first time.

"But this black sonofabitch sure needs a quarter," Shorty sang, grimacing, clowning, ignoring the white man's threat.

"Come on, you black bastard, I got to work," the white man said, intrigued by the element of sadism involved, enjoying it.

"It'll cost you twenty-five cents, Mister White Man; just a quarter, just two bits," Shorty moaned.

There was silence. Shorty threw the lever and the elevator went up and stopped about five feet shy of the floor upon which the white man worked.

"Can't go no more, Mister White Man, unless I get my quarter," he said in a tone that sounded like crying.

"What would you do for a quarter?" the white man asked, still gazing off.

"I'll do anything for a quarter," Shorty sang.

"What for example?" the white asked.

Shorty giggled, swung around, bent over, and poked out his broad, fleshy ass.

"You can kick me for a quarter," he sang, looking impishly at the white man out of the corners of his eyes.

The white man laughed softly, jingled some coins in his pocket, took out one and thumped it to the floor. Shorty stooped to pick it up and the white man bared his teeth and swung his foot into Shorty's rump with all the strength of his body.

Shorty let out a howling laugh that echoed up and down the elevator shaft.

"Now, open this door, you goddam black sonofabitch," the white man said, smiling with tight lips.

"Yeeess siiiir," Shorty sang; but first he picked up the quarter and put it into his mouth.

"This monkey's got the peanuts," he chortled.

He opened the door and the white man stepped out and looked back at Shorty as he went toward his office.

"You're all right, Shorty, you sonofabitch," he said.

"I know it," Shorty screamed, then let his voice trail off in a gale of wild laughter.

I witnessed this scene or its variant at least a score of times and I felt no anger or hatred, only disgust and loathing.

Once I asked him, "How in God's name can you do that?"

"I needed a quarter and I got it," he said soberly proudly.

"But a quarter can't pay you for what he did to you," I said.

"Listen, nigger," he said to me, "my ass is tough and quarters is scarce."

I never discussed the subject with him after that.⁹

It was not until years later, after Wright had come to Chicago, that he realized that Shorty was at war with his environment; that Shorty had to still the fear which arose out of his insecurity; that Shorty had taken over, to an extent, the evaluations which white society had made of him and felt the necessity of being punished when he attempted to get out of his place. Then Wright wrote:

While working in Memphis I had stood aghast as Shorty had offered himself to be kicked by the white man; but now, while working in Chicago, I was learning that perhaps even a kick was better than uncertainty. . . . I had elected, in my fevered search for honorable adjustment to the American scene, not to submit and in doing so I had embraced the daily horror of anxiety, of tension, of eternal disquiet. I could now sympathize with—though I could never bring myself to approve—those tortured blacks who had given up and gone to their white tormentors and said: "Kick me, if that is all there is for me, kick me and let me feel at home, let me have peace!"¹⁰

The mechanism Shorty employed was bizarre but psychologically he handled the problem in a manner similar to many people who belong to a subordinated, frustrated group. Conscious of the hate and contempt which is directed against them because of their color, feeling their own impotence and lack of manhood in the face of such aggression, this extreme in Negro character development turns their aggressions which arise out of their fear, hate, and double fear of the white man, inwardly on themselves. Perhaps Jews have been among the most vicious anti-Semites, and many Negroes have a hatred of the blackness which sets them apart from the rest of the population to be tortured and tormented.

But in the ever mounting rebellion of Negroes the Bigger Thomas mentality is the character formation one most frequently encounters, and their method of handling their anxiety and tension is to rush headlong into the very danger which they so greatly fear.

⁹ Richard Wright, *Black Boy*, *op. cit.*, p. 198. By permission of the publisher.

¹⁰ "Early Days in Chicago," by Richard Wright, *Cross Section 1945*, edited by Edwin Seaver. L. B. Fischer Company, 1945, p. 308. By permission of the publishers.

In all classes of Negroes today one finds less and less of the passive Bigger Thomas' mother and Shorty characters. Many Negroes, perhaps all to some extent, wish to cling to the mask which has in the past enabled them to survive, and become paralyzed with fear at the mere thought of giving up the protection of their passive, submissiveness to the white man. However, the majority of Negroes, in their rage created by the increased consciousness of their position and the humiliations it involves, have thrown off much of their passivity. The white man, to these individuals, is a curious challenge for he is a strong figure to which one element of their personality wishes to be passive but whom, because of the treatment he accords them, they must hate. This hostility is felt as an uneasy tension for it is difficult to want to love and be loved and to hate the same person. Ofttimes a friendly relationship will engender the opposite psychological reaction. A psychoanalyst has related the following incident which illustrates the torturing tensions and anxiety which this dual identification calls forth and describes the way in which some anxiety-ridden Negroes deal with impulses they can neither contain nor resolve:

Several months ago four well-known Negroes spent an afternoon in the discussion of racial discrimination. Naturally this discussion stirred up a great deal of latent bitterness in these four very intelligent men. After several hours, hunger drove them from the room where they had been talking, to a restaurant. They chose a first-class white restaurant.

There the headwaiter greeted them politely and showed them immediately to a table. As so often happens in these days, the waiter was rushing around trying to serve many people.

Probably entirely accidentally, he happened to place a pile of dishes on the table occupied by the four men. It was a high, not too steady tower of dishes resembling a child's tower made of blocks. One of the men said quietly, "What about my knocking these on the floor?"

A second man said with even controlled voice, "Yes, go ahead."

Slowly the first man's hand moved toward the tower. With firm even pressure he moved the dishes nearer and nearer to the edge of the table. The third man in the group watched with fascination the slow motion and could see at the same time terror in the face of a white woman facing him. Her terror was a reflection of his own terror.

The dishes crashed to the floor. There was complete silence in the room and every eye was turned toward the table. The headwaiter rushed up apologizing for the accident. The fear of all the white clients and the four Negroes abated. Life in the restaurant resumed its usual calm course.

You may ask, "What was the point of such behavior?"

Of course it was childish and irrational. It might have been dangerous. Actually, the principal actors in the drama could not be too certain that the consequences of such a childish impulsive act might not be very considerable. How could two intelligent men behave so recklessly and futilely?

The tension of fear aroused by their discussion had become almost unbearable. They felt compelled to relieve that tension by attacking instead of waiting to be attacked. What is called "sweating it out" in the army can be much more frightening than being in actual combat. The unknown expectation of danger seems worse than running to face danger.¹¹

Many white people feel free to give gratuitous advice to Negroes about restraint and are quick to point out that their impulse-ridden behavior injures their cause. All of this is obviously true but fails to recognize the unconscious psychological motives which inspire and command such behavior. These white friends expect the Negro to achieve the impossible. Dr. McLean comments on this point:

The psychological maturity necessary for the white man and the Negro to act maturely and wisely is very much greater for the Negro because his hope of achieving real, tangible satisfactions is much less than for the white man who actually enjoys many real economic privileges. . . . The white man, failing to understand the psychological dilemma in which the Negro frequently finds himself, becomes annoyed and arrogant. He acts like a nagging parent. The whites are much too eager to tell the Negro how to behave and too loath to grant him economic and social opportunities. They have too little understanding of the maturation necessary for self control when the possibility of achieving the goal is so distant. . . .¹²

For those who would deal with any aspect of the Negro question, a more penetrating analysis than is commonly found among scholars today, concerning the Negro's actual problem, the sub-structure of emotional tensions, and the types of character formation resulting therefrom must be obtained before constructive work of real import can be done in this field.

And what about the white man? White people, too, are anxious in their dealings with colored people. They, too, are fear-ridden.

¹¹ "Frightened People," by Dr. Helen V. McLean, an unpublished paper read before the Institute of Race Relations at Fisk University, July 2, 1945

¹² "Unconscious Factors in Race Prejudice," an unpublished paper read before the Institute of Race Relations at Fisk University, July 2, 1945, by Dr. Helen V. McLean.

What is the cause of their deep distress? It is not a rational fear of Negro uprisings though one often hears this fear articulated as a real danger. Obviously, in any contest between Negroes and whites, whites would have superior strength. They have at their command the army, the police force, the economic structure, and can apply violence to enforce their will.

The white man suffers then from an oppressor's phobia—the fear that there will be retribution from those he has humiliated and tortured. The mechanism involved with frightened white people is a guilt-hate-fear complex. Guilt, because his treatment of the American Negro is contrary to all of his higher impulses. Guilt, because with part of himself he believes in the noblest political documents which man has evolved. But having such guilt and being unable and unwilling to resolve it, persons learn to hate the object they feel guilty about so the guilt turns to hate and with it the necessity to rationalize and justify their behavior. Finally there is fear, for the white man in all of his arrogance, knows that in spite of his rationalizations about racial inferiority he would be resentful and strike back if treated the way he treats Negroes. The wave of hysteria which swept the country beginning with the mythical Eleanor Clubs to the so-called bumpers and pushers campaign is eloquent testimony to the operation of this complex of emotions.

To relieve himself of his guilt, to justify his hate, and to expel his fear, white men have erected an elaborate facade of justifications and rationalizations. The Negro is a primitive, dangerous person who must be kept in subordination. Negroes do not have the same high sensibilities as do whites and do not mind exploitation and rejection. Negroes are passive children of nature and are incapable of participating in and enjoying the higher aspects of the general American culture. Negroes would rather be by themselves. Negroes are eaten with tuberculosis and syphilis. But all of these rationalizations do not quell the gnawing knowledge that they, Americans who believe in freedom, believe in the dignity of the human personality, are actively or passively perpetuating a society which defiles all that is human in other human beings. The elaborate attempts to dehumanize the Negro have been successful up to a point, but not to a point whereby those that participate in this cruel drama could do so without guilt, hate, and fear.

Lillian Smith, in an eloquent passage, has analyzed the fears of white men, their infantile and Narcissistic preoccupation with

their own skin color, and their hysterical resistance to emotional growth:

. . . I believe we can find the way if we are willing to look in a new direction for the source of our trouble. We have looked at the "Negro problem" long enough. Now the time has come for us to right-about-face and study the problem of the white man: the deep-rooted needs that have caused him to seek those strange, regressive satisfactions that are derived from worshipping his own skin-color. The white man himself is one of the world's most urgent problems today; not the Negro, not other colored races. We whites must learn to confess this.

There are many among us who think of segregation as merely a Southern tradition, a Southern "custom" that grew out of poverty, out of certain economic patterns, out of certain racial dilemmas when in reality segregation is an ancient psychological mechanism used by men the world over whenever they want to shut themselves away from problems which they fear and do not feel they have the strength to solve. When men get into trouble they tend to put barriers between themselves and their difficulties. We white people got into deep trouble long ago when we attempted to enslave other human beings. A trouble we have never faced and never tried with all our strength to solve. Instead, to shut our troubles from us, we have used a mechanism so destructive that it, in itself, has become a menace to the health of our culture and our individual souls. For segregation as a way of life—or shall we say a *way of death*—is cultural schizophrenia, bearing a curious resemblance to the schizophrenia of individual personality. It is chilling to note the paranoid symptoms of those among us who cling to segregation: their violence, their sensitiveness to criticism, their stereotyped defenses, their inability to identify their overesteem of themselves with the emotional needs of others, their reluctance to reach out and accept new ideas, their profound desire to withdraw from everything hard to face, everything that requires of their personalities further growth.¹³

Clearly there is greater tragedy in this drama of human relationships than the devastating effects of race prejudice on the personality of the Negro. The simple truth is that because of the presence of the Negro and the feeling in our culture about race, both white and black men have a convenient mechanism to avoid arriving at any sort of emotional maturity. Race and race hate present to these immature persons a convenient outlet for their dammed up emotions; provide a defense for their tender egos; constitute a justification for their continued adolescence. It is because of the

¹³ "Addressed to White Liberals," by Lillian Smith, *The New Republic*, September 18, 1944, Vol. III, No. 12, p. 331.

convenient mechanism of race hatred that both Negroes and whites fail to grapple with their personal problems and achieve a maturity which is necessary to have a stable, enriching society.

White people have used the Negro in a variety of ways to perpetuate their own immaturity. On them they can project their impulses of hate which they may feel toward family or friends. The fact that racial prejudice is socially acceptable and not in conflict with the group feelings encourages them to utilize this mechanism rather than solve their personal conflicts. Those neurotic individuals who are afraid of their own sexuality often spread rumors of the sexual atrocities of Negroes. The Negro, by virtue of not really being known, is a common enough sexual symbol to those to whom sex, too, is not understood and therefore something to be feared. If our industrial American civilization has robbed white men of both their dignity as human beings and their economic, emotional and social security, some relief from this deprivation can be found in acting like Gods in attempting to control the fate of Negroes. The compulsive desire to treat all Negroes as "boys" and to make all decisions for them on the part of racial reactionaries is evidence of this attempt to master one's fears by subordinating another human. Even liberals, disillusioned or disappointed with their own group or themselves, will adopt the Negro and expect him to justify all the goals which they have failed to reach themselves. They will become disappointed and angrily impatient if the Negro does not want to play the role of an adolescent child. In desperation these emotionally truncated people, these immature and frightened people, these casualties of our industrial civilization, turn to the Negro to find an object for their frustrated hate and love. . . .

Our failure to achieve a mature culture in which Negroes and whites alike can accomplish some aspect of personality integration has within it the seeds of political fascism. And if the emotionally truncated lives of Negroes lead many of them to give up a fruitless struggle and submit to the certainty of a harsh dictator, many whites, in their immature longing for a meaning of their lives and for a security which they have not been able to find, act in a manner which would indicate that they, too, finding themselves caught in a psychological trap, are longing for the strong though cruel father who will dictate the functions of their lives.

I have tried in this paper to discuss some aspects of the psychological sub-strata of emotion and thought in white and Negro

people alike which arise out of the contradictions of our culture and the frustration that confounds us when we attempt to deal with the problem. That the quality of life for the ordinary Negro in our Northern urban centers is as it is, is a discredit to our country and renders a judgment on our entire way of life.

We who are concerned with the problem of the oppressed, we who are attempting to apply the knowledge and insight gained from empirical research to the problems of a sick society, and are working toward the preservation of the human personality must realize that our knowledge must be deep and profound if we are to make ourselves effective agents for social change. . . .

SECTION VI

The Sociological Approach to Problems Marginal to Mental Disorder

TWENTY-SIX

Distortion of Reality as a Factor in Morale*

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THE REALITY PRINCIPLE IN PSYCHOTHERAPY

"REALITY" is one of the basic concepts of psychiatric theory. The reasons for this emphasis can be stated briefly. Patients with mental or emotional difficulties are troubled in varying degrees with an inability to make accurate appraisals of the situations of daily life, especially normally accurate appraisals of their own dynamics and those of other people. Such deviations are obvious in the case of psychotics, but it is clear that neurotics also fail in more subtle ways to gauge accurately the psychological realities of their own environments and of themselves. Instead, they overestimate or underestimate their own capacities, worry over the imagined reactions of others, exert efforts out of proportion to the value of the goal, or, on the other hand, fail to appreciate the seriousness of the situation. According to psychoanalytical theory the neurotic cannot live wholly with the realities of his present life because he still feels the fears and resentments of early childhood. Haunted by

* Prepared especially for this volume.

unconscious remembrance of things past, he sees the present through the haze of those bygone experiences that disturbed or shocked his psyche. Such a person walks backward into the future with attention fixed, not upon where he is going, but where he has been.

It is the aim of therapy to bring to light these repressed feelings, thereby liberating the patient to deal more realistically with his environment. In long-term treatment innumerable hours are given over to a tedious process of re-education so that more realistic appraisals of the world and its people can be made. As new insights develop, the person also learns to make necessary allowances for his own recognized biases.

Thus, it is clear that the reality principle is fundamental to the work of psychotherapy; yet to advance from this legitimate use to indiscriminate applications of the concept to all manner of situations and people is a long and questionable step. Today we hear people exhorting one another to be "realistic," to "face reality," to avoid "escape mechanisms." Used in this promiscuous way the term has acquired various evaluative meanings. In one sense it suggests that which is hard and unpleasant—reality becoming synonymous with grimness. Freud is partially responsible for this connotation, because he placed the reality principle in opposition to the pleasure principle, thereby suggesting that reality can be equated with unpleasantness.¹ Current stress upon this concept also springs from the human sciences, with their glorification of facts and objectivity of interpretation. Scientific realism is contrasted with the wishful thinking appearing in the accepted formulations of popular belief systems. It is also contrasted with fantasy and projection in individual thought—"where 'fantasy' refers to products of the inner stream of psychic life, and 'projection' refers to the results of idiosyncratic perception, especially when the idiosyncrasy is unrecognized."² Yet it is a gross error to assume that human dynamics must be evaluated exclusively by the criteria of scientific validity. There is a time and a place for the reality principle and there are other occasions in human affairs when distortions of reality serve useful purposes. Some of these latter situations will be presented in the pages which follow. More particularly, the

¹ Sigmund Freud, *Beyond the Pleasure Principle* (New York: Liveright Publishing Company, new translation, 1950).

² Jurgen Ruesch and Gregory Bateson, *Communication* (New York: Norton, 1951), p. 238.

theory will be developed that certain degrees of unreality, far from being a handicap in the world of action, actually contribute to the maintenance of morale.

DISTORTIONS OF REALITY IN NATIONAL CULTURE

In the dynamics of group life it is apparent that all kinds of distortions are conventionalized in order to increase loyalty and morale. In his collective life man evolves systems of belief designed to assist him in the continual struggle to attain his goals. Ends are more desirable, means more energetically pursued if realities can be gilded with attractive colors. Especially where social stability prevails, the *status quo* is viewed as desirable and it is preserved by ideological teachings which support the purposes of the group. In this setting the reality principle has a distinctly limited value.

The concept of ethnocentrism serves to emphasize elements of unreality in all cultures. Each folk considers their ways as best and measures other cultures by their own yardstick. The achievements of the past, the rightness of current practices, the greatness of their destiny—such biased views are widely supported by the members of society. The informal and formal teachings of culture give strong support to the folkways and mores; this process of indoctrination is reinforced by the habits formed in the daily round of activities in one's environment. In a sense it may be said that, when one member lies (in an approved direction), the rest will swear to it. Thus, each culture generates and preserves a set of biases considered appropriate to the on-going life of the group. The "strange," "irrational," or "immoral" ways of other peoples are not likely to receive serious consideration, for to do so would threaten the integrity of the accepted pattern of living. Woe betide those deviants who are open-minded to outside ideologies, for here is subversion that the group will not ignore. Americans, Chinese and Australian aborigines are all expected to follow uncritically the fundamental beliefs and biases of their respective cultures.

Deviations from cultural orthodoxy do not ordinarily constitute a serious threat to group integrity and morale. The majority have little desire to run athwart the conventions but grow up to believe what they are supposed to believe. Some sacrifice of reality seems a small price to pay for social approval, especially since most of

the members of society are not compelled to solve obscure issues of reality and unreality and, consequently, are not aware of any "sacrifice." Only in cultures sanctioning social science and critical public discussions do such issues arise, even to a limited extent. On the other hand, where the ruling hierarchy employs physical force or propaganda and censorship, distortions increase and unreality becomes widely supported.

Yet even in more democratic regimes the distorting influences of patriotism are evident. It comes as a shock to many in this country that the "backward" peoples of Asia believe that they are just as important as the United States of America. In our naive way we tend to think that everyone accepts the goodness and greatness of this country as a permanent feature of the universe. We firmly believe that our actions are always rooted in high moral principles and feel both hurt and misunderstood when our motives are examined by other countries for dollar diplomacy rather than pure humanitarianism. Ethnocentrism is also present in the mores supporting our major institutions. We want to believe in the essential soundness of current practices in the family, in business, in education and in all other fundamental activities. Out of this patriotic faith in his culture the citizen builds loyalty and morale—for peacetime pursuits as well as for the prosecution of wars.

Society is not a debating club. It is a going concern of action whose goals and methods are socially supported; and the well-adjusted individual is one who, by the processes of introjection, transmutes the folkways and mores into personal habits and attitudes. A moralistic husband or wife may harbor illusory notions concerning extramarital relations—at least until they read of the Kinsey findings—but, if their erroneous ideas support marital adjustment, the ideas serve an important purpose for them. Likewise, a successful business man may have strangely distorted conceptions of human dynamics, such as the absolute and permanent necessity of the profit motive in economic affairs, but his provincialism is an integral part of a pattern of business thought.

The hazards of existence also lead us to gild and distort. Poetic and religious euphemisms cushion the harsh impact of death with soft, comforting sentiments. Death is described as a sleep or as release into a better world. In times of illness we anxiously look to the physician for reassurances that everything will turn out well—and, if it seems necessary, he will tell us a few therapeutic lies. Today the most noteworthy example of unreality is the refusal

of many Americans to face the grim possibilities of war. The naive observer, uninitiated in the processes of illusion-building, might surmise that the development of gigantic atom and hydrogen bombs, together with bacteriological warfare, would lead our people to give this problem top priority. But what is the current picture? Civil defense gets small public attention and few funds from Congress. Urban re-development proceeds on the basis of pre-atomic thinking and increases congestion. Conscientious parents who make strenuous efforts to establish a good home and meet the needs of their children will look in amazement when you ask whether they have made plans for their families in the event of war tomorrow. It is all just too horrible to think about.

How shall such escapism be evaluated? We certainly do not condone unpreparedness and public apathy, but we need to appreciate the individual's problem of adjustment. What can he do, in the face of recent technological development, except to indulge in a certain amount of ostrichism? Somehow or other, all of us go about our daily affairs *as if* such threats did not exist. Perhaps the atomic physicists and engineers are working on a bomb five hundred times more destructive than those dropped in Japan, but right now the baby must be fed, the boss is calling for that report, or a party is being planned. Anxiety is demoralizing. In order to meet everyday demands with a minimum of tension it may be necessary for many people to avert their gaze from these grim possibilities and hope for the best.

Escapism in the face of war threats brings to mind another source of conventionalized distortion, namely, the hardy optimism of Americans. Now, the optimistic spirit undoubtedly has survival value for individuals and groups. It signifies faith in what one is doing and in oneself. It suggests an enterprising spirit, self-reliance and great expectations for the future. Yet optimism is bound up with certain degrees of unreality, for the optimist, like the lover, sees what he wants to see. Those aspects of the total situation that do not fit this orientation are ignored or, if recognized dimly, rejected before they emerge into full consciousness. One can witness the restlessness of the confirmed optimist when brought face to face with the failure of some enterprise that he has sponsored. But this momentary contact with unpleasant reality soon gives way to the habitual view. If such a person is in an important administrative position, he may expect subordinates to dispel his doubts. Others seek reassurance from family or friends. In numberless

ways we support each other in rose-colored views of reality and express disapproval against those who attempt to puncture the illusions by which we live. The pessimist is indulging in an un-American activity. We wonder what is wrong with him—he is so negative, perhaps even pathological.

Is an optimistic slant undesirable? Evaluation is always relative to the specific conditions of the given situation. Yet, in general, it can be said that evaluations made within a framework of social and individual action—a dynamic framework—will not necessarily coincide with those made by contemplative objectivity. In the present analysis, which uses this dynamic framework, concepts like “distortion,” “bias,” or “unreality” do not carry the connotations of undesirability commonly associated with them. Thus, optimism has distinct advantages as a builder of morale. In earlier American history when this was a new country with rich resources, expanding industrially and agriculturally, growing in size and power, receiving young, ambitious immigrants from Europe, this spirit provided a dynamic factor of inestimable value. Today, though affected by wars, depression, and dictatorships during the past forty years, our optimism still persists, providing inner strength to meet the problems of these troublous times. Of course, we are not dealing with an all-or-none type of issue here. Optimism without informed reason is blind; knowledge without an optimistic belief in the possibilities of success is sterile in the world of action. A measure of optimism seems to be an essential ingredient of the enterprising spirit.

SPECIALIZATION AND UNREALITY

Elements of unreality appear to be inherent in the outlook of the specialist. Modern society is characterized by an increasing proliferation of structure and function in various institutions, leading to careers which are more specialized, narrow, and bureaucratic. Somehow or other, in the midst of this mounting superstructure, the individual tries to preserve a sense of his significance and worth. In some occupations, such as the routine tasks of the large factory, it is almost impossible to do this; but even in careers of higher status the struggle to maintain an active sense of personal significance may succeed only in part. In this situation a full and steady sense of reality can be a distinct handicap. It may be far better to

lose oneself in a specialty, developing a distorted sense of the significance of one's efforts or—even better—becoming so absorbed in it that such questions do not arise.

The academic profession may be used as an illustration. As subject matter in the various disciplines has broken down into more specialties, scholars concentrate upon knowing more and more about less and less. As a consequence, they can hardly retain a sense of personal worth without overvaluing the particular segments of knowledge where their own proficiency lies. To be sure, a comprehensive view of student needs and interests may be sacrificed when educational vision narrows to the perspective of the bureaucratic pigeonhole; but, in the interest of professional adjustment, faculty members continue to become specialists. And why not? This is the way the academic game is played and how many are radical enough to buck the system? He who follows the rules gains promotions, better offers in other institutions, an impressive string of publications, and reputation as an able scholar. College presidents may give stirring addresses denouncing specialization and professors in obscure colleges may refuse to conform, but these criticisms hardly touch major trends in academic life.³

An aura of unreality may hang over the scholar in his research and writing. It can hardly be his aim to see life steadily and see it whole, for to do so might cost more motivation than he can afford to lose. It is better to cultivate the illusion that the current project, however minuscule, constitutes a significant contribution to human enlightenment. Those naive critics who plead for a realistic sense of proportion in scholarly work do not know whereof they speak, for numerous projects of research would thus diminish to microscopic size and enthusiastic investigators rapidly lose morale. Why plead for an ever-present sense of reality when it would leave many intellectual workers bewildered and frustrated? We insist that the social adjustment of the academic scholar is facilitated by a degree of distortion. Indeed, a fanatical devotion to highly specialized pursuits leads so frequently to competitive success that this spirit and outlook should be encouraged in ambitious youth.

It is the function of administrators to hold together the special-

³ In a few universities it is now possible for the embryonic professor to take broader graduate programs in the social sciences or humanities but it remains to be seen whether this trend will have a significant impact upon Ph. D. education.

ized fragments by developing a broad overview of institutional purposes. Insofar as these officials fulfill their administrative functions, they do bring a more realistic perspective to bear upon major decisions, decisions compounded of many ingredients contributed by various departments and individuals in the organization. Yet we cannot conclude that top administrators are entirely realistic. The leaders of an organization are likely to have ego feelings involved more integrally than the workers farther down the scale. In a real sense they look upon the enterprise as peculiarly theirs: its successes and failures are felt more keenly, its good name is protected by personal pride, and faith in the activity is an aspect of the leader's faith in himself. Thus, the college president wants to believe that the collegiate *status quo* is essentially sound. "Our college is doing an excellent job, the faculty is capable and contented, the students eager and appreciative," he tells himself, looking at the whole organization through a haze of optimism. A realistic appreciation of unsolved problems might ruin his morale, so, to some extent, he lets the wish be father to the thought. Practical men of affairs tend to accept the reality principle—only so far as it is practical to do so. Thus, elements of unreality are involved in the mental adjustments which administrators make to their institutional roles.

Higher education has been used as an illustration but the same principle holds in many other fields of vocational endeavor. A long period of preparatory education, involving time, effort and money, leads the professional person to place a high valuation upon his achieved proficiency. Years of apprenticeship and ambitious striving enhance the value of a business career. In economic life fellow workers support each other's tendencies to overvaluation and the numerous organizations for specialists in this country also contribute to morale by holding conferences, passing resolutions and performing rituals designed to give further sanction to group purposes and ideals. If, out of this multilateral process of indoctrination, the individual begins to magnify the importance of his particular vocation, it should occasion little surprise.

OTHER GROUP ILLUSIONS*

(1) CLASS

Though class lines in the United States are not tightly drawn, the importance of social status is still quite pronounced. Each of the major classes tends to live a distinctive life, including manners, morals, material comforts, group memberships, and civic participation. For this reason we may properly speak of class cultures.

Representatives of the various classes develop a value system which is functionally related to their way of life; and they tend to defend that system whenever it is challenged. This is particularly true of the middle and upper classes, probably less so in the lower strata of society. In the interest of adjustment and morale a person can hardly take a broadly tolerant view of issues relating to philosophy of life, for to do so would introduce complex contradictions into one's class outlook. It is better to adhere unequivocally to the biases (attitudes) appropriate to social status. Many in the upper class hold to the complacent opinion that the cream of society inevitably rises to the top, ignoring the mighty influences of family background and inherited wealth. The middle class often considers itself the salt of the earth. Members of this class commonly assume that all sensible Americans think as they do about issues concerning politics, career, family life, or education. Seldom does the class-bound person carry on any appreciable communication with those of a higher or lower stratum, with the result that he comes to conceive society in his own class image and is ignorant of the mores of other classes in society. Since most of his associates are also class-bound and class-proud, he finds ready support for these illusions. In this way an ethnocentrism of class develops—and it seems to have a favorable effect upon morale. Even those who resist class distortions are not necessarily upholding the reality principle but their resistance may only indicate an ambition to rise into the next higher class where they will acquire another pattern of attitudes with other elements of unreality.

The lowest strata also tend to develop illusions of their own. Members of this class will assert defensively that "all men are

* The relation of religious supernaturalism to morale is a comprehensive subject deserving separate and detailed treatment; hence it is not included here.

created equal" in order to prove that we have no classes in the U. S. A. In this great democracy, it is said, one man is as good as another. Examples of association with the upper class may be cited to support this view—but patterns of dominance and deference in such occasional contacts are conveniently overlooked. At the same time elements of unreality appear in rationalizations which blame their failures upon bad luck, lack of influence, or other face-saving factors.

(2) MINORITIES

Groups affected by the dynamics of prejudice may also show a marked reluctance to face reality. Morale may be seriously handicapped by a full recognition of how certain members of one's subgroup are behaving. Among American Negroes the upper classes do not like to be reminded of the violence and cruelty, the dirt, the ignorance, the sexual behavior and illegitimacy, and the crime of the lower classes. An ambitious Negro youth may insist on believing that there is plenty of room at the top, minimizing the disadvantages of prejudice in the competitive process. Thus, in a dynamic situation, where new opportunities have opened up and upward mobility is evident, wishful thinking flourishes. Some Negroes overestimate the opportunities and achievements of their race, others prefer to underestimate the prevalence of prejudice. Such distortions are widely supported by a humanitarian sentiment that favors a better life for this racial minority. Here we witness how deviations from realistic thought can serve to support and encourage efforts toward racial improvements. Thus, wishful thinking has a positive function in the arena of action: one's dreams stimulate effort—and lo, the dreams may come true.

Similarly, other minorities find it advantageous to eschew demoralizing realities. Jews wear blinders so that they will not see anti-semitism. Indeed, some go to considerable lengths in criticizing other Jews who are sensitive to prejudice, saying that the latter are given to gross exaggeration. Why look unpleasant reality full in the face? A refusal to be fully aware of anti-semitism can have two favorable consequences for Jewish people. (1) It enhances morale. (2) It encourages an attitude of co-operation, relatively free from aggressive rebellion, that wins gentile approval and thus contributes to the long-term reduction of prejudice. Truly, where ignorance is bliss, 'tis folly to be wise.

LOVE AND FRIENDSHIP

Through the ages it has been said that love is blind. Today it is fashionable among students of the family to decry romantic illusions and urge a more realistic point of view. To some extent the new realism is salutary, for it represents the application of informed intelligence to the area of human love in place of ignorance and mysticism. Yet it appears that this trend toward scientific rationalism does not explain altogether the motivations of teachers and textbook writers in criticizing romanticism. Perhaps the disillusionments of middle age are also involved as well as the general suspicion of the tender emotions that seems to be part of the puritanical mind.

From whatever source it arises, this type of realism fails to understand the value of unrealities in heterosexual love. The dependent person, seeking security in the love of another, may magnify the other's strength and dependability because of this inner need. The man or woman craving affectionate understanding may exaggerate the loved one's capacity to give such understanding. Elements of unreality are quite apparent in these cases but are they necessarily harmful? Shall the illusions of love be destroyed to satisfy an irresponsible urge for a more objective realism? Here is a naivete more remarkable than that of the maligned romanticist, for it emanates from scientists who are supposed to understand human dynamics. Now it cannot be denied that heterosexual love is a major factor in human happiness. It provides motivation and morale, gives comforting solace in times of stress, and injects new purpose into one's life. Who dares to invoke the reality principle in the face of these essential considerations?

Similar unrealities can be found in parental conception of their children. Conventionally we expect a certain amount of illusion on the part of parents, who frequently have exaggerated notions regarding the capacities and achievements of their sons and daughters. Such overvaluations are viewed sympathetically; indeed, we may be surprised when these are absent. This tendency to overvalue the child seems to have two main sources. First, as in the case of heterosexual love, the bias is dictated by the emotional needs of the parents. Second, overvaluation is a concomitant of the middle-class philosophy of child rearing, according to which parents should give unlimited time and attention of the healthy develop-

ment of their several children. Here we again ask, how shall these conventional degrees of unreality be evaluated? Shall the emotional satisfactions of parenthood be thwarted by the kill-joy spirit implicit in realism?

Of course, numerous problems arise when conceptions depart too far from reality. In marriage the sentimental bias may lead to great expectations which the loved one cannot possibly fulfill—a situation causing distress to both. Grossly unreal conceptions of children lead to disappointment where achievement does not, and cannot, measure up to expectations. Such parents may nag their children in genteel ways and create unhappiness all around. Be this as it may, it is still true that elements of unreality normally constitute an integral part of family sentiment without doing appreciable damage.

On a lower level of emotional intensity the same principle is evident in friendly relations. We are biased in favor of our friends. Feeling the congenial warmth of the relationship, we tend to overlook qualities and actions that contradict this sentiment. Someone has said—was it Thomas Huxley?—that, in contrast with the teachings of the Sermon on the Mount, he loved only his friends and hated his enemies. Is this not true of the normal person? We are unrealistic, at least to some extent, where our friends are concerned and insist on thinking the best of them. We may place too high a value on their advice, recommend them recklessly for new positions, and denounce those who criticize them. In a sense, all of us play politics where friends are involved: they have our recommendation because we like them, not because they are, in the cold light of reason, eminently qualified for the position under consideration. Such biases are given open approval in a culture that stresses the value of friendship.

At the same time our friends are expected to build up our morale. They praise our achievements and minimize our failures, thereby enhancing favorable self-conceptions. To be sure, objective truth has its place—but not among friends. Do not all of us readily forgive a friend's bias in supporting those little fictions by which we live? Probably everyone pulls his punches where friends are concerned. Conversely, they are doing the same for you, softening the harsh impact of reality. In this way, a person's friends are part of a pleasant conspiracy to keep him in good spirits.

TO THINE OWN SELF BE TRUE?

Finally we shall add a word about unreality in self attitudes. The business of living calls for a reasonably high order of morale—how can the individual manage to live successfully amid the vicissitudes of life unless he has substantial faith in himself? Now such faith is not based simply upon a persisting sense of reality. It does involve a sense of reality, to be sure, in contrast with the distortions of an inferiority complex; but it also includes an optimistic affirmation of self—a life-affirming belief in what one is doing and in the decisions and purposes by which one lives from day to day. Faith in oneself is a pragmatic value of the first order, a value that has its psychological origins in a family situation where the child obtains plenty of love and understanding. Yet its functional value in a competitive environment is not to be confused with precise conformity to reality. Realistic appraisals are based upon objective awareness and assessment of the various factors in the total situation whereas, in the self-affirming distortion, all ego-deflating factors tend to be minimized or ignored. In a word, a person simply cannot afford to give much attention to those who would question his choices, cast aspersions upon his motives, or belittle his efforts. Good morale demands that we steadfastly adhere to a bias favorable to the self.

Even in psychiatry it is an open question as to how far therapy promotes realistic conceptions of self. Since self-depreciation is a common neurotic symptom, it is understandable that therapy aims to develop self-appraisals which are less pessimistic and more conducive to morale. To this end it becomes important to counteract tendencies to self-depreciation by encouraging the development of attitudes favorable to self-appreciation and self-reliance. This is good mental hygiene, of course, but it is hardly pure realism.

MORALE VERSUS POLICY-MAKING

By this time it should be clear that the discussion is concerned exclusively with the relation between certain distortions of reality and morale. It is the present theory that the purposes of individuals or groups are supported by the operation of a bias which selects those aspects of reality that augment motivation, satisfy demands of the ego or of group status, and justify a favorable evaluation of

the final accomplishment. We have chosen examples of this relationship from contemporary American society. Our frame of reference is a dynamic one, that is, emphasis has been placed upon distortions of reality which tend to increase persistence and enthusiasm in the pursuit of individual or collective purposes.

The value of such conventionalized distortions in policy-making is a different issue altogether. Obviously, purposes are not always harmonious, so that one purpose is often advanced at the expense of another. A nation at war strives for good morale, but this is not to the advantage of its enemies nor will it necessarily advance world peace. A highly specialized worker may have good morale but faulty judgment on policy matters. The limited conceptions of class-bound thought can cause many difficulties, as in the case of middle-class teachers who fail to understand the background or motives of their lower-class pupils. Or, as the Kinsey studies suggest, members of the judiciary commonly evaluate sexual behavior on the basis of their own particular class ideals and affix penalties accordingly. Finally, family and friends may be a hindrance by failing to state criticisms that would be helpful.

Thus, in society the failure to be realistic can lead to numerous difficulties, just as neurotic individuals suffer distress and show poor judgment in harboring deep-seated distortions of thought and feeling. But this is the well-known thesis of the reality principle and it has been stated time and time again by psychologists and social scientists. Here we have given attention to a neglected aspect of the question, namely, the positive role of conventionalized unrealities in helping to build morale.

WHAT IS REALITY?

In the foregoing pages it has been assumed that reality and unreality can be determined and differentiated in a satisfactory manner; indeed, if this were not so, the whole analysis would collapse into a hopeless subjectivity wherein one man's meat is another's poison. Fortunately this is not the case. *An objective assessment of sociological data can be made in exactly the same way as in psychotherapy, namely, by the knowledge and judgment of the scientific expert.* Just as the psychiatrist is competent to judge degrees of reality or unreality in the patient's interpretations, so the social scientist is equipped to determine the distortions of collective thought and the purposes these serve or fail to serve. The historian

or political scientist possesses the special ability to identify nationalistic bias. The sociologist studying the vocations, class, race, or the family develops an objective understanding that serves as a reference point in determining degrees of distortion in social life. These scientists know that the biases favorable to morale are not occasional deviations to be expunged by research and education, for they seem to be indigenous to culture and social living. Therefore, to invoke the reality principle indiscriminately and uncompromisingly is to weaken man's adjustment to the environment in which his life is cast. As a participating member of society he inevitably accepts and assimilates certain conventionalized distortions of reality in the interest of good morale.

Suicide: An Instance of High Rural Rates *

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INTRODUCTION

THE PHENOMENON of suicide has attracted interest for centuries and has been observed in all contemporary societies as well as in many preliterate groups. Although there has been a marked increase in the number of suicides in industrialized, urbanized societies, suicides have been committed since the beginning of recorded history. Irrespective of trends, the phenomenon of suicide provides the social scientist with an opportunity for investigation of numerous problems concerning the interrelations, dynamics, and processes of interaction of the individual and society.

Although there are relatively few scientific works in the field, some sociologists have treated the problem at considerable length. Works by H. Morselli, Emile Durkheim, Ruth Cavan, and Louis I. Dublin and Bessie Bunzel are among the most important sociological works in English; the works of Gregory Zilboorg and Karl Menninger are noteworthy psychological studies. It would appear that the major contributions to the study of suicide have come from the fields of actuarial science (including sociological interpretation) and from psychoanalytical psychiatry. Unfortunately, there has been little work attempting to interrelate the two areas.¹

* From *Rural Sociology*, 18 (March, 1953), 45-52. Reprinted by permission of the authors and the publisher.

¹ In the first category of suicide studies, see H. Morselli, *Suicide* (New York: D. Appleton & Co., 1882); Emile Durkheim, *Suicide*, translated by George Simpson (Glencoe, Ill.: The Free Press, 1951); Ruth Cavan, *Suicide* (Chicago: University of Chicago Press, 1928); L. I. Dublin and B. Bunzel, *To Be or Not to Be* (New York: Smith and Haas, 1933); Maurice Halbwachs, *Les Causes du Suicide* (Paris: Librairie Felix Alcan, 1930); F. L. Hoffman, *Suicide Problems* (Newark: The Prudential Press, 1927); A. L. Porterfield, R. H. Talbert, and H. R. Mundkenke, *Crime, Suicide and Social Well-Being* (Fort Worth: Texas Christian University, 1948); Calvin Schmid, *Suicides in Seattle, 1914-1925: An Ecological and Behavioristic Study* (Seattle: The University

Since 1940, the suicide rates for the United States have declined. The primary factors contributing to this decline are twofold. First, the nation has been engaged in warfare, or prospective warfare, during most of the decade. It has been observed repeatedly that the suicide rate drops during periods of national crisis. Although the reason has not been definitely established, some have suggested that the feeling of unity and solidarity often characteristic of such a period decreases the intensity of personal problems, thus reducing the suicide rate.² The second factor affecting the suicide rate during this period has been the tremendous increase in the number of young persons in the population. It has been shown that suicide is primarily a function of middle and old age.³ The introduction of many children into a population, therefore, increases the size of the population base on which the crude death rate from suicide is computed, but it does not increase the number of suicides.

On the basis of previous studies, the following are among the important generalizations concerning suicide in the United States and Western Europe:

1. Suicides are more common among males than females; the ratio is usually two or three to one.
2. Suicide rates increase with age.
3. The suicide rate is higher in cities than in rural areas.
4. The suicide rate is higher among Protestants than among Catholics.
5. Suicide rates among Negroes are lower than among whites in the United States.
6. Suicide rates vary widely between countries and between sections of the same country.

of Washington Press, 1928); C. P. Loomis in the United States Strategic Bombing Survey, *The Effects of Bombing on German Morale*, Volume II (1946); and C. P. Loomis, *Studies of Applied and Theoretical Social Science* (East Lansing: Michigan State College Press, 1950), chaps. 21 and 22.

In the second category of suicide studies, see especially Karl A. Menninger, *Man Against Himself* (New York: Harcourt, Brace and Co., 1938); Sigmund Freud, *Collected Papers*, Vol. IV (London: The Hogarth Press, 1949); Gregory Zilboorg, "Suicide Among Civilized and Primitive People," *The American Journal of Psychiatry*, XCII (1935-1936), 1347-69; E. Y. Williams, "Some Observations on the Psychological Aspects of Suicide," *The Journal of Abnormal and Social Psychology*, XXXI (1935-36), 260-265; and Margarethe von Andics, *Suicide and the Meaning of Life* (London: William Hodge and Co., 1947).

² See Durkheim, *op. cit.*, and Dublin and Bunzel, *op. cit.*

³ See for example "Change in Rank of Leading Causes of Death," *Statistical Bulletin, Metropolitan Life Insurance Company*, Vol. 31, No. 6 (June, 1950).

PURPOSE OF STUDY, AND PROCEDURES USED

As a by-product of a general mortality study sponsored by the Michigan Agricultural Experiment Station,⁴ it was discovered that some of the previously stated generalizations were not true for Michigan; the most important of these concerned the rural-urban suicide differential: The rural rate was considerably higher than the urban rate.⁵ Heretofore, both empirical evidence and theoretical propositions have indicated that the reverse condition would be expected. The purpose of this paper, therefore, is to present an analysis of suicides in Michigan and to suggest reasons for the observed reversal in suicide rates.

The data used in this study were collected from information available on the death certificates of suicides filed in the Bureau of Records and Statistics of the Michigan Department of Health, in Lansing. Data were collected for the years 1945 through 1949.⁶ These data were coded and punched on IBM cards and analyzed by machine methods. The death certificates contained the following information, some of which could not be utilized in this study: Place of occurrence, place of residence, age, sex, race, place of death, date of death, method used in committing suicide, length of stay in community prior to death, marital status, birthplace, birthplace of father, birthplace of mother, occupation, disposition of body on death, and, in the case of removals, the place to which the body was removed.⁷

In the analysis of the data for Michigan it is assumed that a statistical analysis of suicide data is meaningful. The authors do not agree with the contention of some workers that the data are

⁴ Paul M. Houser and J. Allan Beegle, *Mortality Differentials in Michigan* (East Lansing: Michigan AES Special Bulletin 367, Feb., 1951).

⁵ The census definition of rural and urban was used by the Department of Health in classifying death certificates by residence. Thus, rural suicides, as considered here, include persons residing on farms, in villages under 2,500 population, in fringe areas, and in other rural-nonfarm areas.

⁶ 3,081 cases of suicide in Michigan were examined.

⁷ Obviously a complete analysis of all of the data cannot be reported in this paper. The data have yielded extremely interesting hypotheses concerning migration *per se*, as well as factors responsible for varying rates of removal of the deceased for burial. The death certificates were incomplete in some cases. The data on length of stay in the community prior to death, for example, were so incomplete that it was impossible to make any statistical generalizations from them.

too inadequate to merit credence.⁸ Undoubtedly, some cases of suicide have been concealed, and desired information is often lacking. It is felt, however, that while the data do not include all cases of suicide, the sample available, with some qualification, is fairly representative of the entire universe. Some selective factors may be at work which distort the data. For example, more suicides may be concealed among those in the higher socio-economic stratum, because of the greater concern for social approval which members of this class may feel. However, for most of the analyses which have been made, errors of this kind will not affect validity.

Suicide in Western countries is considered to be the result of personal disorganization. Thus, it is considered highly individualized and differs sharply from the institutionalized suicides of the Orient. Obviously the individualized suicide is the only type considered here, since the social milieu does not sanction the ritualistic suicide. Various factors which may contribute to personal disorganization were isolated and the suicide rates for various combinations of factors were determined. It is recognized that no absolute etiology can result from a study of this kind, but it is felt that an indication of the conditions which foster suicidal tendencies will aid the worker who attempts to interrelate demographic and case history data. By utilizing the data concerning several variables, those kinds of conditions which tend to promote suicide may be inferred.

THE FINDINGS

Table 1 indicates the crude suicide rates for Michigan by residence and sex for the period under study, 1945-1949.⁹ The most striking condition shown in the table is that the suicide rate for

⁸ See for example Zilboorg, *op. cit.*

⁹ Population estimates were made from 1940 census data and preliminary 1950 census reports. In most cases, a linear interpolation between 1940 and 1950 data was made. Interpolations were checked against population estimates made by the Michigan Department of Health. Although the interpolations may have overestimated the rural-to-urban migration of males, thereby creating a spuriously high rural male suicide rate, the authors do not believe this to be the case, since higher rural suicide rates for males were observed in 1940 when enumeration data were available. In 1940, the age-adjusted suicide rate for males in Michigan was 31 per cent higher than the corresponding urban rate. For a detailed account of population estimate procedures, see W. Widick Schroeder, "Suicide Differentials in Michigan" (unpublished Master's thesis, Michigan State College, 1951), pp. 32-36.

TABLE 1. SUICIDE RATES BY RESIDENCE AND SEX, MICHIGAN, 1945-1949

Sex	Rate per 100,000		
	Total Population	Urban Population	Rural Population
All	10.2	9.2	11.7
Male	14.7	12.6	22.0
Female	4.7	4.7	4.5

rural male residents is almost twice as high as the rate for urban male residents. An examination of the rates by age, residence, and sex indicates a similar comparison for corresponding age groups among males. (See Table 2.) Tables 3 and 4 give the suicide rates by age, sex, residence, and nativity. From these data it is apparent that no hypothesis attributing the rural-urban differentials in Michigan to unique age, sex, or nativity conditions can be validated. The phenomenon is a fact; contrary to *a priori* expectations, the rural suicide rate among males is higher than the urban suicide rate. For females, the evidence is inconclusive, since the rates are about equal.

TABLE 2. SUICIDE RATES BY RESIDENCE, SEX, AND AGE, MICHIGAN, 1945-1949

Age	Rate per 100,000			
	Rural Population		Urban Population	
	Males	Females	Males	Females
10-14	*0.0	10.0	*0.0	10.0
15-19	*5.3	*0.9	2.5	*0.7
20-24	*13.5	*3.1	6.6	3.8
25-29	19.2	*3.3	8.8	4.7
30-34	18.8	5.0	11.4	5.3
35-39	29.4	*4.5	15.1	6.8
40-44	29.3	6.2	17.8	8.0
45-49	20.9	10.0	19.2	8.8
50-54	21.8	14.2	22.7	10.2
55-59	47.7	10.0	29.7	14.3
60-64	43.0	11.9	32.7	10.3
65-69	60.6	*6.9	32.1	11.3
70-74	52.9	*14.3	32.4	11.1
75 and over	47.9	*10.2	42.5	9.1

* Indicates rates based upon less than 20 suicides.

† No suicides.

TABLE 3. SUICIDE RATES OF NATIVE-BORN WHITES BY RESIDENCE, SEX, AND AGE, MICHIGAN, 1945-1949

Age	Rate per 100,000			
	Rural Population		Urban Population	
	Males	Females	Males	Females
15-19	*6.4	*1.4	2.9	*0.7
20-24	15.2	*3.1	7.2	4.7
25-29	19.6	*3.3	9.8	4.7
30-34	19.2	*4.7	12.9	5.8
35-39	30.2	*2.9	16.2	6.7
40-44	27.9	*6.0	18.9	7.7
45-49	21.6	8.5	18.8	8.0
50-54	20.3	13.8	18.4	10.6
55-59	45.4	*8.9	22.2	14.3
60-64	38.9	*13.1	23.9	11.6
65-69	50.4	*6.2	19.6	*10.3
70-74	46.7	*12.9	31.2	*9.1
75 and over	41.4	*10.0	36.2	*8.0

* Indicates rates based upon less than 20 suicides.

TABLE 4. SUICIDE RATES OF FOREIGN-BORN POPULATION BY RESIDENCE, SEX, AND AGE, MICHIGAN, 1945-1949

Age	Rate per 100,000			
	Males		Females	
	Rural	Urban	Rural	Urban
15-19	†0.0	†0.0	} 10.0	} †0.0
20-24	†0.0	*5.0		
25-29	†0.0	*13.3	} *10.0	} *9.4
30-34	*10.0	*15.0		
35-39	*23.5	*18.5	} *20.0	} *9.7
40-44	*44.0	19.0		
45-49	*14.3	23.6	} *13.3	} 11.3
50-54	*28.9	35.8		
55-59	52.7	44.1	} *12.0	} 11.3
60-64	49.1	48.5		
65-69	80.0	64.7	} *14.0	} *14.1
70-74	76.9	35.0		
75 and over	67.4	56.4	*11.1	*10.0

* Indicates rates based upon less than 20 suicides.

† No suicides.

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Suicide rates by occupational class are given in Table 5. Unfortunately, the desired base population data for occupational groups are unavailable. The only information listed by the census is the number of males and females in the specified occupations. No age distribution information, which is essential for a meaningful suicide analysis, is available. However, if it is assumed that the age distribution for the several occupations is approximately the same, the rates may be of some value.

TABLE 5. SUICIDE RATES BY OCCUPATION AND SEX, MICHIGAN, 1945-1949

Occupation	Rate per 100,000	
	Males	Females †
Professional and semiprofessional	16.2	4.6
Farmers and farm managers	53.6	*0.0
Proprietors, managers, and officials	18.8	*5.5
Clerical, sales, and kindred workers	13.9	3.6
Craftsmen, foremen, operatives, and kindred workers	15.9	*2.8
Service workers	30.5	4.5
Farm laborers	14.5	*0.0
Other laborers	23.2	*0.0

† Those classified as "housewives" have been omitted from this table.

* Indicates rates based upon less than 20 suicides.

Farmers exhibit suicide rates which are almost twice as high as those of male service workers, who have the second highest rate. An examination of the age distribution of farmer-suicides revealed a higher percentage of suicides in the older age brackets than was the case for most other occupations. This situation should be considered in the light of two limitations of these data. First, the recorders who complete death certificates probably list more retired farmers as "farmers" than they list other retired workers by their occupations. Second, the occupation is easy to categorize; hence, it is probable that a higher percentage of those persons who engage in this occupation are properly classified.

Table 6 indicates the occupational distribution of white male suicides by residence. Of major interest is the fact that only 32 per cent of the rural white male suicides were farmers. Three per cent were listed as farm laborers. Thus, only about one-third were engaged in occupations directly related to rural life. Most of the remaining two-thirds of the rural white male suicides were engaged

in occupations which are urban-oriented. Houser and Beegle have suggested that the high suicide rate of rural males is derived from the frustration and personal disorganization which have resulted from the conflict in rural and urban values. Their study showed "... that suicides in Michigan are concentrated in the agricultural counties of southern Michigan, in two counties of the Thumb area, in a cluster of western coastal counties in the middle part of the lower peninsula, and in the western half of the upper peninsula."¹⁰ They offer the hypothesis that the frustration and personal disorganization which have resulted from the conflict in the rural and urban values have been most severe among farmers whose rural way of life had been the most satisfying, and, consequently, the most idealized.¹¹

TABLE 6. DISTRIBUTION OF WHITE MALE SUICIDES BY OCCUPATION, FOR RURAL AND URBAN AREAS, MICHIGAN, 1945-1949 (Percentages of All Suicides in Each Area)

Occupation	Rural	Urban
Professional and semiprofessional	*2.0	4.6
Farmers and farm managers	32.1	1.8
Proprietors, managers, and officials	5.4	7.4
Clerical, sales, and kindred workers	3.3	7.3
Craftsmen, foremen, operatives, and kindred workers	19.8	34.1
Service workers	2.7	8.0
Farm laborers	2.9	*0.2
Other laborers	7.0	4.0
Students	*1.1	*1.4
Not ascertainable	18.0	23.0
Retired	5.7	8.2
Total	100.0	100.0

* Less than 20 suicides in this group.

In the light of the foregoing occupational data, it would appear that this explanation of the high rural rate is only partial. These data would suggest that not only has the farmer experienced a conflict in values which has led to frustrations and personal dis-

¹⁰ Houser and Beegle, *op. cit.*, pp. 54-56.

¹¹ A close relationship between suicide and population increase through migration is indicated for American cities. See C. P. Loomis and J. A. Beegle, *Rural Social Systems* (New York: Prentice-Hall, Inc., 1950), p. 406.

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organization, but also that many rural residents who commit suicide in Michigan are actually urban-oriented in terms of occupational pursuits. Fringe-dwellers swell the rural suicide rate.¹² The decision of such individuals to commit suicide may have its origin in an incomplete reconciliation of rural and urban values.

One of the most interesting aspects of the age-specific data, shown in Table 7, is the variability of suicides with the seasons of

TABLE 7. DISTRIBUTION OF ALL MALE SUICIDES BY AGE, RESIDENCE, AND SEASON, MICHIGAN, 1945-1949 (*Percentages of all suicides in each category*)

Season	Place of Residence and Age					
	Rural					
	20-29	30-39	40-49	50-59	60-69	70-79
Spring	18.5	32.5	35.2	33.0	30.2	24.0
Summer	22.2	23.8	21.2	25.6	27.3	24.9
Autumn	29.7	24.7	21.2	21.8	23.3	31.7
Winter	29.6	19.0	22.4	19.6	19.2	19.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Season	Place of Residence and Age					
	Urban					
	20-29	30-39	40-49	50-59	60-69	70-79
Spring	22.6	27.0	28.1	25.6	27.4	28.5
Summer	21.9	27.9	22.0	26.6	27.0	26.7
Autumn	24.0	23.9	23.0	24.8	22.4	21.0
Winter	31.5	21.2	26.9	23.0	23.2	23.8
Total	100.0	100.0	100.0	100.0	100.0	100.0

Note: The following definition of the seasons is employed: spring—March, April, and May; summer—June, July, and August; autumn—September, October, and November; winter—December, January, and February.

the year. The seasonal variation observed by Durkheim was that the highest suicide rate occurred in the spring and the lowest rate in the winter. This does not hold true for the Michigan data when

¹² It was impossible to separate "fringe" residents from other rural residents in this study. Although a separation of the fringe residents as a special category was attempted, it was impossible to allocate the addresses of the suicides with any degree of accuracy. The extension of street names and numbers into the rural parts of the state rendered accurate allocation impossible, especially in areas for which detailed maps were not available.

age- and sex-specific percentages are computed. The highest percentage of suicides among young males in both rural and urban areas occurs in the autumn and winter rather than in the spring and summer. If this variation is not due to mere chance, Durkheim's observations would seem to be characteristic of later adulthood, for the 30-39 age group shows percentages characteristic of the typically observed composite pattern. The writers are not in a position to hypothesize concerning this situation, without access to case-history materials.

As Dublin and Bunzel have pointed out, three factors are of considerable importance in determining the choice of the method that the suicide uses to commit the act. These factors are: (1) the accessibility of the means, (2) the power of suggestion, and (3) the psychological set of the individual.¹³ Table 8 indicates the means which the Michigan suicides employed to commit the act. These data show that there are considerable differences in this respect between rural and urban areas, between the sexes, and between age groups. It appears improbable that the observed differences between the various groups could be explained on the basis of different motivation. Such differences can be explained more adequately on the basis of the devices that were readily available and the means common to a particular generation. For example, strangulation is more common among the aged than poison, a method commonly employed by young people. It would appear that the different era in which the two groups matured would suggest the method they would employ. Poison was uncommon and difficult to obtain a generation or two ago. Today, it is readily available and, in the case of the barbiturates, it is widely used medicinally. Differences in rural and urban means may readily be explained on the basis of the availability of the means.

SUMMARY

This study has demonstrated that the rural-urban suicide differential in Michigan cannot be explained by unique age, sex, racial, or nativity distributions on the part of rural and urban segments of Michigan's population. The rural male suicide rate in Michigan is higher for both the native-born and the foreign-born

¹³ Dublin and Bunzel, *op. cit.*, pp. 69-71.

TABLE 8. DISTRIBUTION OF SUICIDES BY AGE,*
SEX, RESIDENCE, AND CAUSE OF DEATH,
MICHIGAN, 1945-1949 (Percentage of all
suicides in each category)

Cause of Death	Age, Residence, and Sex					
	Rural Males			Urban Males		
	20-29	40-49	60-69	20-29	40-49	60-69
Poisoning (solid or liquid)	6.2	4.8	4.0	10.6	7.8	3.7
Poisonous gases	4.9	7.9	4.0	13.5	12.0	6.1
Hanging or strangulation	18.5	17.6	35.4	25.6	26.5	31.8
Drowning	1.2	1.8	3.0	6.0	3.2	9.0
Firearms and explosives	63.0	64.9	44.5	39.9	41.0	33.1
Cutting or piercing instruments	2.5	1.2	7.1	0.7	3.5	8.6
Jumping	1.2	1.8	0.0	2.3	2.8	4.9
Crushing	2.5	0.0	0.5	0.7	1.4	2.0
Other	0.0	0.0	1.5	0.7	1.8	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Cause of Death	Rural Females			Urban Females		
	20-29	40-49	60-69	20-29	40-49	60-69
	20-29	40-49	60-69	20-29	40-49	60-69
Poisoning (solid or liquid)	20.8	28.9	12.1	45.0	17.8	14.0
Poisonous gases	0.0	6.7	0.0	2.9	10.9	7.0
Hanging or strangulation	20.8	26.7	48.5	13.1	39.6	42.2
Drowning	0.0	4.4	15.2	10.1	7.9	8.8
Firearms and explosives	45.9	26.7	21.2	21.8	12.9	7.0
Cutting or piercing instruments	0.0	2.2	0.0	1.4	3.0	10.5
Jumping	0.0	0.0	0.0	1.4	5.9	7.0
Crushing	4.2	0.0	0.0	4.3	2.0	0.0
Other	8.3	4.4	3.0	0.0	0.0	3.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

* Illustrative age categories representing young adults, the middle-aged, and the elderly are given. The other age categories are omitted, to simplify presentation.

white male residents for almost all age groups. Two factors have been suggested to account for this. First, as urban values and ideals become more widely disseminated in rural areas, the conflict in rural and urban values becomes more intense. This conflict offers greater possibilities for maladjustment and personal disorganization among rural people. Second, the data that have been presented in this paper indicate that the majority of rural white males who commit suicide are engaged in occupations which are

characteristic of urbanized groups. Though they live in the country (including fringe areas) they are urban-oriented in terms of occupation and mental attitudes. Nonetheless, Michigan farmers and farm managers as an occupational group exhibit extraordinarily high suicide rates.

Becoming a Marihuana User*

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THE USE of marihuana is and has been the focus of a good deal of attention on the part of both scientists and laymen. One of the major problems students of the practice have addressed themselves to has been the identification of those individual psychological traits which differentiate marihuana users from nonusers and which are assumed to account for the use of the drug. That approach, common in the study of behavior categorized as deviant, is based on the premise that the presence of a given kind of behavior in an individual can best be explained as the result of some trait which predisposes or motivates him to engage in the behavior.¹

This study is likewise concerned with accounting for the presence or absence of marihuana use in an individual's behavior. It starts, however, from a different premise: that the presence of a given kind of behavior is the result of a sequence of social experiences during which the person acquires a conception of the meaning of the behavior, and perceptions and judgments of objects and situations, all of which make the activity possible and desirable. Thus, the motivation or disposition to engage in the activity is built up in the course of learning to engage in it and does

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¹ See, as examples of this approach, the following: Eli Marcovitz and Henry J. Meyers, "The Marihuana Addict in the Army," *War Medicine*, VI (December, 1944), 382-91; Herbert S. Gaskill, "Marihuana, an Intoxicant," *American Journal of Psychiatry*, CII (September, 1945), 202-4; Sol Charen and Luis Perelman, "Personality Studies of Marihuana Addicts," *American Journal of Psychiatry*, CII (March, 1946), 674-82.

not antedate this learning process. For such a view it is not necessary to identify those "traits" which "cause" the behavior. Instead, the problem becomes one of describing the set of changes in the person's conception of the activity and of the experience it provides for him.²

This paper seeks to describe the sequence of changes in attitude and experience which lead to *the use of marihuana for pleasure*. Marihuana does not produce addiction, as do alcohol and the opiate drugs; there is no withdrawal sickness and no ineradicable craving for the drug.³ The most frequent pattern of use might be termed "recreational." The drug is used occasionally for the pleasure the user finds in it, a relatively casual kind of behavior in comparison with that connected with the use of addicting drugs. The term "use for pleasure" is meant to emphasize the noncompulsive and casual character of the behavior. It is also meant to eliminate from consideration here those few cases in which marihuana is used for its prestige value only, as a symbol that one is a certain kind of person, with no pleasure at all being derived from its use.

The analysis presented here is conceived of as demonstrating the greater explanatory usefulness of the kind of theory outlined above as opposed to the predispositional theories now current. This may be seen in two ways: (1) predispositional theories cannot account for that group of users (whose existence is admitted) ⁴ who do not exhibit the trait or traits considered to cause the behavior and (2) such theories cannot account for the great variability over time of a given individual's behavior with reference to the drug. The same person will at one stage be unable to use the drug for pleasure, at a later stage be able and willing to do so, and, still later, again be unable to use it in this way. These changes, difficult to explain from a predispositional or motivational theory, are readily understandable in terms of changes in the individual's conception of the drug as is the existence of "normal" users.

The study attempted to arrive at a general statement of the sequence of changes in individual attitude and experience which

² This approach stems from George Herbert Mead's discussion of objects in *Mind, Self, and Society* (Chicago: University of Chicago Press, 1934), pp. 277-80.

³ Cf. Roger Adams, "Marihuana," *Bulletin of the New York Academy of Medicine*, XVIII (November, 1942), 705-30.

⁴ Cf. Lawrence Kolb, "Marihuana," *Federal Probation*, II (July, 1938), 22-25; and Walter Bromberg, "Marihuana: A Psychiatric Study," *Journal of the American Medical Association*, CXIII (July 1, 1939), 11.

have always occurred when the individual has become willing and able to use marihuana for pleasure and which have not occurred or not been permanently maintained when this is not the case. This generalization is stated in universal terms in order that negative cases may be discovered and used to revise the explanatory hypothesis.⁵

Fifty interviews with marihuana users from a variety of social backgrounds and present positions in society constitute the data from which the generalization was constructed and against which it was tested.⁶ The interviews focused on the history of the person's experience with the drug, seeking major changes in his attitude toward it and in his actual use of it and the reasons for these changes. The final generalization is a statement of that sequence of changes in attitude which occurred in every case known to me in which the person came to use marihuana for pleasure. Until a negative case is found, it may be considered as an explanation of all cases of marihuana use for pleasure. In addition, changes from use to nonuse are shown to be related to similar changes in conception, and in each case it is possible to explain variations in the individual's behavior in these terms.

This paper covers only a portion of the natural history of an individual's use of marihuana,⁷ starting with the person having arrived at the point of willingness to try marihuana. He knows that others use it to "get high," but he does not know what this means in concrete terms. He is curious about the experience, ignorant of what it may turn out to be, and afraid that it may be more than he has bargained for. The steps outlined below, if he undergoes them all and maintains the attitudes developed in them, leave him willing and able to use the drug for pleasure when the opportunity presents itself.

⁵ The method used is that described by Alfred R. Lindesmith in his *Opiate Addiction* (Bloomington: Principia Press, 1947), chap. i. I would like also to acknowledge the important role Lindesmith's work played in shaping my thinking about the genesis of marihuana use.

⁶ Most of the interviews were done by the author. I am grateful to Solomon Kobrin and Harold Finestone for allowing me to make use of interviews done by them.

⁷ I hope to discuss elsewhere other stages in this natural history.

I

The novice does not ordinarily get high the first time he smokes marihuana, and several attempts are usually necessary to induce this state. One explanation of this may be that the drug is not smoked "properly," that is, in a way that insures sufficient dosage to produce real symptoms of intoxication. Most users agree that it cannot be smoked like tobacco if one is to get high:

Take in a lot of air, you know, and . . . I don't know how to describe it, you don't smoke it like a cigarette, you draw in a lot of air and get it deep down in your system and then keep it there. Keep it there as long as you can.

Without the use of some such technique^a the drug will produce no effects, and the user will be unable to get high:

The trouble with people like that [who are not able to get high] is that they're just not smoking it right, that's all there is to it. Either they're not holding it down long enough, or they're getting too much air and not enough smoke, or the other way around or something like that. A lot of people just don't smoke it right, so naturally nothing's gonna happen.

If nothing happens, it is manifestly impossible for the user to develop a conception of the drug as an object which can be used for pleasure, and use will therefore not continue. The first step in the sequence of events that must occur if the person is to become a user is that he must learn to use the proper smoking technique in order that his use of the drug will produce some effects in terms of which his conception of it can change.

Such a change is, as might be expected, a result of the individual's participation in groups in which marihuana is used. In them the individual learns the proper way to smoke the drug. This may occur through direct teaching:

I was smoking like I did an ordinary cigarette. He said, "No, don't do it like that." He said, "Suck it, you know, draw in and hold it in your lungs till you . . . for a period of time."

I said, "Is there any limit of time to hold it?"

He said, "No, just till you feel that you want to let it out, let it out." So I did that three or four times.

^a A pharmacologist notes that this ritual is in fact an extremely efficient way of getting the drug into the blood stream (R. P. Walton, *Marihuana: America's New Drug Problem* [Philadelphia: J. B. Lippincott, 1938], p. 48).

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Many new users are ashamed to admit ignorance and, pretending to know already, must learn through the more indirect means of observation and imitation:

I came on like I had turned on [smoked marihuana] many times before, you know. I didn't want to seem like a punk to this cat. See, like I didn't know the first thing about it—how to smoke it, or what was going to happen, or what. I just watched him like a hawk—I didn't take my eyes off him for a second, because I wanted to do everything just as he did it. I watched how he held it, how he smoked it, and everything. Then when he gave it to me I just came on cool, as though I knew exactly what the score was. I held it like he did and took a poke just the way he did.

No person continued marihuana use for pleasure without learning a technique that supplied sufficient dosage for the effects of the drug to appear. Only when this was learned was it possible for a conception of the drug as an object which could be used for pleasure to emerge. Without such a conception marihuana use was considered meaningless and did not continue.

II

Even after he learns the proper smoking technique, the new user may not get high and thus not form a conception of the drug as something which can be used for pleasure. A remark made by a user suggested the reason for this difficulty in getting high and pointed to the next necessary step on the road to being a user:

I was told during an interview, "As a matter of fact, I've seen a guy who was high out of his mind and didn't know it."

I expressed disbelief: "How can that be, man?"

The interviewee said, "Well, it's pretty strange, I'll grant you that, but I've seen it. This guy got on with me, claiming that he'd never got high, one of those guys, and he got completely stoned. And he kept insisting that he wasn't high. So I had to prove to him that he was."

What does this mean? It suggests that being high consists of two elements: the presence of symptoms caused by marihuana use and the recognition of these symptoms and their connection by the user with his use of the drug. It is not enough, that is, that the effects be present; they alone do not automatically provide the experience of being high. The user must be able to point them out to himself and consciously connect them with his having

smoked marihuana before he can have this experience. Otherwise, regardless of the actual effects produced, he considers that the drug has had no effect on him: "I figured it either had no effect on me or other people were exaggerating its effect on them, you know. I thought it was probably psychological, see." Such persons believe that the whole thing is an illusion and that the wish to be high leads the user to deceive himself into believing that something is happening when, in fact, nothing is. They do not continue marihuana use, feeling that "it does nothing" for them.

Typically, however, the novice has faith (developed from his observation of users who do get high) that the drug actually will produce some new experience and continues to experiment with it until it does. His failure to get high worries him, and he is likely to ask more experienced users or provoke comments from them about it. In such conversations he is made aware of specific details of his experience which he may not have noticed or may have noticed but failed to identify as symptoms of being high:

I didn't get high the first time. . . . I don't think I held it in long enough. I probably let it out, you know, you're a little afraid. The second time I wasn't sure, and he [smoking companion] told me, like I asked him for some of the symptoms or something, how would I know, you know. . . . So he told me to sit on a stool. I sat on—I think I sat on a bar stool—and he said, "Let your feet hang," and then when I got down my feet were real cold, you know.

And I started feeling it, you know. That was the first time. And then about a week after that, sometime pretty close to it, I really got on. That was the first time I got a big laughing kick, you know. Then I really knew I was on.

One symptom of being high is an intense hunger. In the next case the novice becomes aware of this and gets high for the first time:

They were just laughing the hell out of me because like I was eating so much. I just scoffed [ate] so much food, and they were just laughing at me, you know. Sometimes I'd be looking at them, you know, wondering why they're laughing, you know, not knowing what I was doing. [Well, did they tell you why they were laughing eventually?] Yeah, yeah, I come back, "Hey, man, what's happening?" Like, you know, like I'd ask, "What's happening?" and all of a sudden I feel weird, you know. "Man, you're on, you know. You're on pot [high on marihuana]." I said, "No, am I?" Like I don't know what's happening.

The learning may occur in more indirect ways:

I heard little remarks that were made by other people. Somebody said, "My legs are rubbery," and I can't remember all the remarks that were made because I was very attentively listening for all these cues for what I was supposed to feel like.

The novice, then, eager to have this feeling, picks up from other users some concrete referents of the term "high" and applies these notions to his own experience. The new concepts make it possible for him to locate these symptoms among his own sensations and to point out to himself a "something different" in his experience that he connects with drug use. It is only when he can do this that he is high. In the next case, the contrast between two successive experiences of a user makes clear the crucial importance of the awareness of the symptoms in being high and re-emphasizes the important role of interaction with other users in acquiring the concepts that make this awareness possible:

[Did you get high the first time you turned on?] Yeah, sure. Although, come to think of it, I guess I really didn't. I mean, like that first time it was more or less of a mild drunk. I was happy, I guess, you know what I mean. But I didn't really know I was high, you know what I mean. It was only after the second time I got high that I realized I was high the first time. Then I knew that something different was happening.

[How did you know that?] How did I know? If what happened to me that night would of happened to you, you would've known, believe me. We played the first tune for almost two hours—one tune! Imagine, man! We got on the stand and played this one tune, we started at nine o'clock. When we got finished I looked at my watch, it's a quarter to eleven. Almost two hours on one tune. And it didn't seem like anything.

I mean, you know, it does that to you. It's like you have much more time or something. Anyway, when I saw that, man, it was too much. I knew I must really be high or something if anything like that could happen. See, and then they explained to me that that's what it did to you, you had a different sense of time and everything. So I realized that that's what it was. I knew then. Like the first time, I probably felt that way, you know, but I didn't know what's happening.

It is only when the novice becomes able to get high in this sense that he will continue to use marihuana for pleasure. In every case in which use continued, the user had acquired the necessary concepts with which to express to himself the fact that he was ex-

perienicing new sensations caused by the drug. That is, for use to continue, it is necessary not only to use the drug so as to produce effects but also to learn to perceive these effects when they occur. In this way marihuana acquires meaning for the user as an object which can be used for pleasure.

With increasing experience the user develops a greater appreciation of the drug's effects; he continues to learn to get high. He examines succeeding experiences closely, looking for new effects, making sure the old ones are still there. Out of this there grows a stable set of categories for experiencing the drug's effects whose presence enables the user to get high with ease.

The ability to perceive the drug's effects must be maintained if use is to continue; if it is lost, marihuana use ceases. Two kinds of evidence support this statement. First, people who become heavy users of alcohol, barbiturates, or opiates do not continue to smoke marihuana, largely because they lose the ability to distinguish between its effects and those of the other drugs.⁹ They no longer know whether the marihuana gets them high. Second, in those few cases in which an individual uses marihuana in such quantities that he is always high, he is apt to get this same feeling that the drug has no effect on him, since the essential element of a noticeable difference between feeling high and feeling normal is missing. In such a situation, use is likely to be given up completely, but temporarily, in order that the user may once again be able to perceive the difference.

III

One more step is necessary if the user who has now learned to get high is to continue use. He must learn to enjoy the effects he has just learned to experience. Marihuana-produced sensations are not automatically or necessarily pleasurable. The taste for such experience is a socially acquired one, not different in kind from acquired tastes for oysters or dry martinis. The user feels dizzy, thirsty; his scalp tingles; he misjudges time and distances; and so on. Are these things pleasurable? He isn't sure. If he is to continue

⁹ "Smokers have repeatedly stated that the consumption of whiskey while smoking negates the potency of the drug. They find it very difficult to get 'high' while drinking whiskey and because of that smokers will not drink while using the 'weed'" (cf. New York City Mayor's Committee on Marihuana, *The Marihuana Problem in the City of New York* [Lancaster, Pa.: Jacques Cattell Press, 1944], p. 13).

marihuana use, he must decide that they are. Otherwise, getting high, while a real enough experience, will be an unpleasant one he would rather avoid.

The effects of the drug, when first perceived, may be physically unpleasant or at least ambiguous:

It started taking effect, and I didn't know what was happening, you know, what it was, and I was very sick. I walked around the room, walking around the room trying to get off, you know; it just scared me at first, you know. I wasn't used to that kind of feeling.

In addition, the novice's naïve interpretation of what is happening to him may further confuse and frighten him, particularly if he decides, as many do, that he is going insane:

I felt I was insane, you know. Everything people done to me just wiggled me. I couldn't hold a conversation, and my mind would be wandering, and I was always thinking, oh, I don't know, weird things, like hearing music different. . . . I get the feeling that I can't talk to anyone. I'll goof completely.

Given these typically frightening and unpleasant first experiences, the beginner will not continue use unless he learns to redefine the sensations as pleasurable:

It was offered to me, and I tried it. I'll tell you one thing. I never did enjoy it at all. I mean it was just nothing that I could enjoy. [Well, did you get high when you turned on?] Oh, yeah, I got definite feelings from it. But I didn't enjoy them. I mean I got plenty of reactions, but they were mostly reactions of fear. [You were frightened?] Yes. I didn't enjoy it. I couldn't seem to relax with it, you know. If you can't relax with a thing, you can't enjoy it, I don't think.

In other cases the first experiences were also definitely unpleasant, but the person did become a marihuana user. This occurred, however, only after a later experience enabled him to redefine the sensations as pleasurable:

[This man's first experience was extremely unpleasant, involving distortion of spatial relationships and sounds, violent thirst, and panic produced by these symptoms.] After the first time I didn't turn on for about, I'd say, ten months to a year. . . . It wasn't a moral thing; it was because I'd gotten so frightened, bein' so high. An' I didn't want to go through that again, I mean, my reaction was, "Well, if this is what they call bein' high, I don't dig [like] it." . . . So I didn't turn on for a year almost, accounta that. . . .

Well, my friends started, an' consequently I started again. But I didn't have any more, I didn't have that same initial reaction, after I started turning on again.

[In interaction with his friends he became able to find pleasure in the effects of the drug and eventually became a regular user.]

In no case will use continue without such a redefinition of the effects as enjoyable.

This redefinition occurs, typically, in interaction with more experienced users who, in a number of ways, teach the novice to find pleasure in this experience which is at first so frightening.¹⁰ They may reassure him as to the temporary character of the unpleasant sensations and minimize their seriousness, at the same time calling attention to the more enjoyable aspects. An experienced user describes how he handles newcomers to marihuana use:

Well, they get pretty high sometimes. The average person isn't ready for that, and it is a little frightening to them sometimes. I mean, they've been high on lush [alcohol], and they get higher that way than they've ever been before, and they don't know what's happening to them. Because they think they're going to keep going up, up, up till they lose their minds or begin doing weird things or something. You have to like reassure them, explain to them that they're not really flipping or anything, that they're gonna be all right. You have to just talk them out of being afraid. Keep talking to them, reassuring, telling them it's all right. And come on with your own story, you know: "The same thing happened to me. You'll get to like that after awhile." Keep coming on like that; pretty soon you talk them out of being scared. And besides they see you doing it and nothing horrible is happening to you, so that gives them more confidence.

The more experienced user may also teach the novice to regulate the amount he smokes more carefully, so as to avoid any severely uncomfortable symptoms while retaining the pleasant ones. Finally, he teaches the new user that he can "get to like it after awhile." He teaches him to regard those ambiguous experiences formerly defined as unpleasant as enjoyable. The older user in the following incident is a person whose tastes have shifted in this way, and his remarks have the effect of helping others to make a similar redefinition:

A new user had her first experience of the effects of marihuana and became frightened and hysterical. She "felt like she was half in and half

¹⁰ Charen and Perelman. *op. cit.*, p. 679.

out of the room" and experienced a number of alarming physical symptoms. One of the more experienced users present said, "She's dragged because she's high like that. I'd give anything to get that high myself. I haven't been that high in years."

In short, what was once frightening and distasteful becomes, after a taste for it is built up, pleasant, desired, and sought after. Enjoyment is introduced by the favorable definition of the experience that one acquires from others. Without this, use will not continue, for marihuana will not be for the user an object he can use for pleasure.

In addition to being a necessary step in becoming a user, this represents an important condition for continued use. It is quite common for experienced users suddenly to have an unpleasant or frightening experience, which they cannot define as pleasurable, either because they have used a larger amount of marihuana than usual or because it turns out to be a higher-quality marihuana than they expected. The user has sensations which go beyond any conception he has of what being high is and is in much the same situation as the novice, uncomfortable and frightened. He may blame it on an overdose and simply be more careful in the future. But he may make this the occasion for a rethinking of his attitude toward the drug and decide that it no longer can give him pleasure. When this occurs and is not followed by a redefinition of the drug as capable of producing pleasure, use will cease.

The likelihood of such a redefinition occurring depends on the degree of the individual's participation with other users. Where this participation is intensive, the individual is quickly talked out of his feeling against marihuana use. In the next case, on the other hand, the experience was very disturbing, and the aftermath of the incident cut the person's participation with other users to almost zero. Use stopped for three years and began again only when a combination of circumstances, important among which was a resumption of ties with users, made possible a redefinition of the nature of the drug:

It was too much, like I only made about four pokes, and I couldn't even get it out of my mouth, I was so high, and I got real flipped. In the basement, you know, I just couldn't stay in there anymore. My heart was pounding real hard, you know, and I was going out of my mind; I thought I was losing my mind completely. So I cut out of this basement, and this other guy, he's out of his mind, told me, "Don't, don't leave me, man. Stay here." And I couldn't.

I walked outside, and it was five below zero, and I thought I was dying, and I had my coat open; I was sweating, I was perspiring. My whole insides were all . . . , and I walked about two blocks away, and I fainted behind a bush. I don't know how long I laid there. I woke up, and I was feeling the worst, I can't describe it at all, so I made it to a bowling alley, man, and I was trying to act normal, I was trying to shoot pool, you know, trying to act real normal, and I couldn't lay and I couldn't stand up and I couldn't sit down, and I went up and laid down where some guys that spot pins lay down, and that didn't help me, and I went down to a doctor's office. I was going to go in there and tell the doctor to put me out of my misery . . . because my heart was pounding so hard, you know. . . . So then all week end I started flipping, seeing things there and going through hell, you know, all kinds of abnormal things. . . . I just quit for a long time then.

[He went to a doctor who defined the symptoms for him as those of a nervous breakdown caused by "nerves" and "worries." Although he was no longer using marihuana, he had some recurrences of the symptoms which led him to suspect that "it was all his nerves."] So I just stopped worrying, you know; so it was about thirty-six months later I started making it again. I'd just take a few pokes, you know. [He first resumed use in the company of the same user-friend with whom he had been involved in the original incident.]

A person, then, cannot begin to use marihuana for pleasure, or continue its use for pleasure, unless he learns to define its effects as enjoyable, unless it becomes and remains an object which he conceives of as capable of producing pleasure.

IV

In summary, an individual will be able to use marihuana for pleasure only when he goes through a process of learning to conceive of it as an object which can be used in this way. No one becomes a user without (1) learning to smoke the drug in a way which will produce real effects; (2) learning to recognize the effects and connect them with drug use (learning, in other words, to get high); and (3) learning to enjoy the sensations he perceives. In the course of this process he develops a disposition or motivation to use marihuana which was not and could not have been present when he began use, for it involves and depends on conceptions of the drug which could only grow out of the kind of actual experience detailed above. On completion of this process he is willing and able to use marihuana for pleasure.

He has learned, in short, to answer "Yes" to the question: "Is it fun?" The direction his further use of the drug takes depends on his being able to continue to answer "Yes" to this question and, in addition, on his being able to answer "Yes" to other questions which arise as he becomes aware of the implications of the fact that the society as a whole disapproves of the practice: "Is it expedient?" "Is it moral?"¹¹ Once he has acquired the ability to get enjoyment out of the drug, use will continue to be possible for him. Considerations of morality and expediency, occasioned by the reactions of society, may interfere and inhibit use, but use continues to be a possibility in terms of his conception of the drug. The act becomes impossible only when the ability to enjoy the experience of being high is lost, through a change in the user's conception of the drug occasioned by certain kinds of experience with it.

In comparing this theory with those which ascribe marihuana use to motives or predispositions rooted deep in individual behavior, the evidence makes it clear that marihuana use for pleasure can occur only when the process described above is undergone and cannot occur without it. This is apparently so without reference to the nature of the individual's personal makeup or psychic problems. Such theories assume that people have stable modes of response which predetermine the way they will act in relation to any particular situation or object and that, when they come in contact with the given object or situation, they act in the way in which their makeup predisposes them.

This analysis of the genesis of marihuana use shows that the individuals who come in contact with a given object may respond to it at first in a great variety of ways. If a stable form of new behavior toward the object is to emerge, a transformation of meanings must occur, in which the person develops a new conception of the nature of the object.¹² This happens in a series of communicative acts in which others point out new aspects of his experience to him, present him with new interpretations of events, and help him achieve a new conceptual organization of his world, without

¹¹ Another paper will discuss the series of developments in attitude that occurs as the individual begins to take account of these matters and adjust his use to them.

¹² Cf. Anselm Strauss, "The Development and Transformation of Monetary Meanings in the Child," *American Sociological Review*, XVII (June, 1952), 275-86.

which the new behavior is not possible. Persons who do not achieve the proper kind of conceptualization are unable to engage in the given behavior and turn off in the direction of some other relationship to the object or activity.

This suggests that behavior of any kind might fruitfully be studied developmentally, in terms of changes in meanings and concepts, their organization and reorganization, and the way they channel behavior, making some acts possible while excluding others.

TWENTY-NINE

Alcoholism*

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ALCOHOLISM is an anomalous type of condition which has proved difficult to classify with precision. As yet there are many factors in both the etiology and symptomatology of alcoholism which are not completely understood. But it is clearly recognized that the condition manifests itself in a complex variety of symptoms of which some are physical in nature, some reflect serious emotional disturbance, and some involve maladaptation to the social environment. Causes are generally believed to involve factors both of personality development and of environment. Although not yet positively identified, the existence of some physiological basis for alcoholism is also considered quite possible.

The Subcommittee on Alcoholism of the World Health Organization defines the condition as covering "those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance, or an interference with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning; or who show the prodromal signs of such developments."¹

Estimates based on the definition and formulae adopted by WHO suggest that there are about four million alcoholics in the United States plus an undetermined number of individuals who may incidentally drink to the extent that they become involved in difficulties but who do not manifest chronic and progressive characteristics of pathological drinking.²

* Prepared especially for this volume.

¹ World Health Organization, *Expert Committee on Mental Health, Alcoholism Subcommittee, Second Report*, Technical Report Series No. 48 (August, 1952), p. 16.

² E. M. Jellinek, "The Estimate of the Number of Alcoholics in the U. S. A. for 1949 in the Light of the Sixth Revision of the International Lists of Causes

For the sociologist, alcoholism is unique in that it can occur only in persons who happen to participate in a particular social custom: the drinking of alcoholic beverages.³ The use of beverages containing alcohol is a custom deeply rooted in the folkways of many cultures. It was introduced to this country with the first settlers and in varying forms it has always played a rather important part in the economic and social life of a substantial segment of our population.⁴ Most recent estimates suggest that nearly 60 million adults in the United States are users of alcoholic beverages.⁵ The act of drinking itself is not a cause of alcoholism. About 94 per cent of the drinkers in this country never experience most of the reactions common to the alcoholic. However, these 60 million drinkers constitute the "exposed population," for alcoholism obviously does not occur outside of their ranks. When certain of the emotional responses and behavior traits characteristic of the alcoholic occur in nonalcoholics it is not unusual to find other deviant behavior such as drug addiction, "addictive" sexual patterns, or impulsive eating leading to gross obesity.⁶

Studies of various groups of problem drinkers in the United States have revealed striking differences in the prevalence of alcoholism among persons with different cultural backgrounds. In particular it has been observed that persons of Italian nationality background and persons who identify themselves as Jewish have low rates of alcohol pathology despite the fact that the custom of using alcoholic beverages is followed by a majority of the adults in both groups. On the other hand, the Irish, among whom fewer adults are drinkers, show very high rates of problem drinking.⁷

of Death," *Quarterly Journal of Studies on Alcohol*, XIII (June, 1953), 215-218. The estimate given is 3,852,000.

³ Selden D. Bacon, *Sociology and the Problems of Alcohol* (New Haven: Journal of Studies on Alcohol, Inc., 1944).

⁴ Robert Straus and Selden D. Bacon, *Drinking in College* (New Haven: Yale University Press, 1953). See especially chapter 2, "Drinking Customs and Attitudes in American Society."

⁵ American Institute of Public Opinion, News release dated September 26, 1951, "Survey Reveals 57,500,000 Drinkers in U. S. Today." (These were of age 21 and above.) Similar findings were reported by John W. Riley, Jr. and Charles F. Marden, "The Social Pattern of Alcoholic Drinking," *Quarterly Journal of Studies on Alcohol*, VIII (September, 1947), 265-273.

⁶ See Giorgio Lolli, M. D., "The Addictive Drinker," *Quarterly Journal of Studies on Alcohol*, X (December, 1949), 404-414.

⁷ See Howard W. Haggard, M. D. and E. M. Jellinek, *Alcohol Explored* (New York: Doubleday, 1942), p. 252; also, Riley and Marden, *op. cit.*

A number of theories have been offered to explain these differences. It has been suggested, for example, that drinking among Jews has traditionally been associated with the most important sanctions in orthodox Jewish life and that this "ritual attitude" tends to make drinking for the effects of alcohol seem profane.⁸ Among Italians the traditional conception of wine as a form of food is inconsistent with the idea of drinking for the effect. Among both Jewish and Italian groups the frequent preference for beverages with a low alcohol content and the patterns of drinking at meals or in the accompaniment of food limit the level of alcohol blood concentration which the drinker can achieve under ordinary circumstances.⁹ Studies of both Italian and Jewish¹⁰ groups report the presence of some individuals who show certain personality traits often seen in the alcoholic and who have developed an impulsive eating pattern instead of addictive drinking.

Among the Irish, drinking customs prescribe beverages with relatively high alcohol content such as distilled spirits, and drinking seldom is accompanied by food. Both of these practices enable the Irish drinker to achieve a higher blood alcohol concentration when he drinks and are consistent with the suggestion that Irish drinking customs are of "utilitarian" nature and place stress on the achievement of "good feeling."¹¹

Studies of drinking customs and the relationship between drinking and other aspects of behavior while still in the exploratory stage suggest one of the most fruitful sources of knowledge about etiology of alcoholism.

⁸ See Robert Freed Bales, "The 'Fixation Factor' in Alcohol Addiction: An Hypothesis Derived from a Comparative Study of Irish and Jewish Social Norms" (unpublished Ph.D. dissertation, Harvard University, 1944), and R. F. Bales, "Cultural Differences in Rates of Alcoholism," *Quarterly Journal of Studies on Alcohol*, VI (March, 1946), 480-499.

⁹ Giorgio Lolli, M. D., et al., "Relationships Between Intake of Carbohydrate-Rich Food and Intake of Wine and Other Alcoholic Beverages," *Quarterly Journal of Studies on Alcohol*, XIII (September, 1952), 401-420.

¹⁰ Charles R. Snyder and Ruth H. Landman, "Prospectus for Sociological Research on Jewish Drinking Patterns," *Quarterly Journal of Studies on Alcohol*, XII (September, 1951), 451-474.

¹¹ Bales (1944 and 1946) *op. cit.* For a somewhat different viewpoint see Donald D. Glad, "Attitudes and Experiences of American-Jewish and American-Irish Male Youth as Related to Differences in Adult Rates of Inebriety," *Quarterly Journal of Studies on Alcohol*, VIII (December, 1947), 406-472.

For many decades in the United States, alcoholism—along with such disorders as tuberculosis, venereal diseases, and cancer—was unmentionable. Its victims were so stigmatized that the secret of their difficulty was carefully guarded by family members, friends and fellow workers. For the public at large, the concept of alcoholism has, until quite recently, been associated primarily with the very limited segments of the alcoholic population whose problem could not be hidden. These were the inmates of alcoholic wards in public hospitals for the mentally ill or were the men who live from day to day in the missions, shelters, or doorways of deteriorated "skid row" areas in our larger cities, including those who are repeatedly arrested and committed to public jails. It is around these painfully obvious segments of the alcoholic population that many stereotyped beliefs were formed and indiscriminately applied to alcoholics as a whole. As a result the stigma was perpetuated and most public efforts to deal with the problem were restricted to provisions for the derelict and deeply disturbed elements.

More realistic and effective responses to the problems of alcoholism began to take place in the late 1930's and gained momentum during the decade of the 1940's. These responses involved three distinct but closely related aspects: the phenomenon of Alcoholics Anonymous, the development of intensive scientific interest and activity, and a public health movement stemming from broad programs of public education and the establishment of numerous treatment facilities by both voluntary and official agencies.¹²

Alcoholics Anonymous is a completely unprofessional group and does not subscribe to any traditional disciplined theory of underlying etiology or to medical diagnosis and facilities. Members rely chiefly on a nonsectarian, spiritual philosophy and program by which they make themselves available at all time to help fellow members maintain their sobriety.¹³ The essentials of the Alcoholics Anonymous program include many elements of known therapeutic value.¹⁴

¹² Raymond G. McCarthy, "Public Health Approach to the Control of Alcoholism," *American Journal of Public Health*, XL (November, 1950), 1412-1417.

¹³ For official statements on the Alcoholics Anonymous program see *Alcoholics Anonymous* (New York: Works Publishing Co., 1939), and *A. A. Tradition* (New York: Works Publishing Co., 1947).

¹⁴ Several sociologists have studied various aspects of the Alcoholics Anonymous program. See Robert Freed Bales, "The Therapeutic Role of Alcoholics

The broad significance of the Alcoholics Anonymous movement is not limited to the estimated 120,000 members who have found help in achieving and maintaining sobriety. By its dramatic demonstration of the fact that the alcoholic represented all walks of life and could be reclaimed as a useful, productive, respectable, and reasonably well-integrated member of the community, Alcoholics Anonymous has made a most significant contribution to programs of public education and to the gradual removal of stigma and taboo. It has also stimulated interest in scientific investigations designed to facilitate diagnosis, treatment, and prevention. Individual members have helped establish voluntary health groups on both national and local levels and have worked for state legislation aimed at improving knowledge about alcoholism and facilities for coping with its problems. Frequently Alcoholics Anonymous groups cooperate closely with professional treatment resources.

Professional efforts to cope with alcoholism have received leadership from an interdisciplinary group at Yale University. Since about 1940 various problems relating to alcoholic beverages have been studied at the Yale Center of Alcohol Studies through the disciplines of physiology, biochemistry, medicine, law, education, religion, psychology, economics, and sociology. The Yale group has also engaged in such varied activities as publishing services, advisory services, a School of Alcohol Studies, and an experimental clinic. Like Alcoholics Anonymous, the Yale program, along with other professional studies, has contributed significantly to making alcoholism seem less disreputable and has provided the stimulus and guidance for the establishment of many action programs throughout the country.

Public response to alcoholism has taken form with the establishment of numerous voluntary and official agencies. Local voluntary health groups concerned with alcoholism now exist in about 60 cities. Most of these are affiliated with the National Committee on Alcoholism, which was founded in 1944 to increase public under-

Anonymous as Seen by a Sociologist," *Quarterly Journal of Studies on Alcohol*, V (September, 1944), 267-278; Oscar W. Ritchie, "A Sociohistorical Survey of Alcoholics Anonymous," *Quarterly Journal of Studies on Alcohol*, IX (June, 1948), 119-156; Milton A. Maxwell, "Social Factors in the Alcoholics Anonymous Program" (unpublished Ph.D. dissertation, University of Texas, 1949); Mary M. Murphy, "Social Class Differences in Responsiveness to the Program of Alcoholics Anonymous" (unpublished Ph.D. dissertation, University of Chicago, 1952).

standing in this area. In 1945, Connecticut became the first state to pass legislation providing for tax-supported education and treatment facilities relating to alcoholism. By 1954, forty-three states had either created new agencies or charged existing agencies with studying the problem or providing services or both.¹⁵

The most significant aspect of the emergence of modern therapy for alcoholics has been the development of specialized community clinics for diagnosis and treatment of alcoholism. Prototypes were first established on an experimental basis by the Yale group in Hartford and New Haven, in 1944. In 1954 about 80 clinic facilities for alcoholics are in operation in many parts of the country. Most of these clinics combine the co-ordinated efforts of internist, psychiatrist, clinical psychologist, and psychiatric social worker. They try to provide the individual patient with an insight into his own drinking problem and to help him alter his living arrangements so that he can more satisfactorily adjust to his social and physical environment without alcohol. The most effective clinic arrangements also utilize general hospital facilities for the treatment of acute phases of alcoholism. For those individuals who are more maladjusted socially the use of convalescent services and a gradual return to community living with outpatient clinic guidance is frequently indicated.

The development of a new approach toward the problems of alcoholism in recent years has made it possible to describe a large number of people who, while not fitting the traditional stereotypes of the deteriorated inebriate, nevertheless suffer from alcoholism and its malign consequences for themselves, their families and society. These are men and women who are likely to get married and living with their families, to have histories of steady employment in positions requiring skill and responsibility and to be at least partly integrated as members of their communities.¹⁶ As long

¹⁵ Staff of the Yale Center of Alcohol Studies, "Alcoholism 1941-1951; A Survey of Activities in Research, Education and Therapy," *Quarterly Journal of Studies on Alcohol*, XIII (September, 1952), 422-511.

¹⁶ Robert Straus and Selden D. Bacon, *Alcoholism and Social Stability* (New Haven: Hillhouse Press, 1951). Earlier studies which placed greater stress on the social isolation of alcoholics include Harriet R. Mowrer, "Alcoholism and the Family," *Journal of Criminal Psychopathology*, III (1941), 96-99; Harriet R. Mowrer and Ernest R. Mowrer, "Ecological and Familial Factors Associated with Inebriety," *Quarterly Journal of Studies on Alcohol*, VI (June, 1945), 36-44; and Selden D. Bacon, *Inebriety, Social Integration and Marriage* (New Haven: Journal of Studies on Alcohol, Inc., 1945).

as public facilities for dealing with alcoholics were limited to public jails, shelters, and mental hospitals, these alcoholics usually escaped recognition unless they were overcome by physical, mental, or social deterioration. Even when they reached a point where continuing relationships became intolerable for employers, friends, and family, the true nature of their difficulty was often concealed, denied, or ignored. Only with the emergence of Alcoholics Anonymous, the growing impact of public education and the removal of stigmas about alcoholism, and the establishment of specialized clinical facilities where alcoholics of this type could seek help, has it become possible to identify this segment of the alcoholic population. These men and women who still possess certain social assets often present the most favorable prognosis and readjustment potential.

The patient who has experienced years of social isolation bereft of normal experiences of personal interaction is often lacking in many of the basic techniques for getting along with other people. The treatment of such a patient is complicated by the fact that, even if he learns to live without alcohol, his life usually has no meaningful orientation. Furthermore, the thought of adjusting to life in normal society suggests many strange and frightening experiences, made all the more painful if they must be met without the anxiety-depressing effects of alcohol. Indeed, usually there seems to be far greater incentive for the patient to seek an anesthetic from the realities of his marginal existence.

On the other hand, psychological and physiological factors being equal, prognosis for recovery tends to be favorable when patients have families, have lived or still live with other people in regularly established households, have permanent ties with a community, or have held forms of stable employment. The therapist is at a distinct advantage when his patients have retained at least some ties with the normal social institutions and with common interpersonal relationships; when, in short, the positive aspects of no longer drinking are supported by the incentives of achieving social and psychological integration and adjustment. Furthermore, the man with social assets can draw on activities and companionship to help him get over periods of crises in his recovery process. The importance of such support has been dramatically illustrated by the Alcoholics Anonymous program.

Recently studies have revealed that the majority of the patients who are seen in modern alcoholism treatment facilities differ mark-

edly from the stereotyped alcoholic in the number of social assets which they can muster.¹⁷ At the same time, studies of the deteriorated homeless man population reveal dominant drinking patterns and motivations which are distinctly different from the clinical concept of alcohol addiction.¹⁸

These conclusions can be illustrated by summarizing studies of two different groups of alcoholics which will be designated as "clinic patients" and "homeless men."¹⁹

During 1950 a study was made of the records of 2,023 male patients seen in nine different community outpatient clinics. Five of these clinics were located in Connecticut, the others in New Hampshire, Oregon, Pennsylvania and Texas. All of these patients were clinically diagnosed as alcoholics. The majority displayed what will be described as an addictive drinking pattern. Four groups of homeless men were studied in New Haven in 1945 and in New York City in 1950, 1952 and 1953. Although it was not possible to make psychiatric diagnoses, and medical diagnoses were limited to a small percentage of the subjects, it was possible to label between 80 and 90 per cent of the homeless men as pathological drinkers, simply because alcohol had dominated their lives. They

¹⁷ Esther P. Walcott and Robert Straus, "Use of a Hospital Facility in Conjunction with Outpatient Clinics in the Treatment of Alcoholics," *Quarterly Journal of Studies on Alcohol*, XIII (March, 1952), 60-77; also Straus and Bacon (1951) *op. cit.*

¹⁸ Robert Straus and Raymond G. McCarthy, "Nonaddictive Pathological Drinking Patterns of Homeless Men," *Quarterly Journal of Studies on Alcohol*, XII (December, 1951), 601-611. McCarthy and Straus have also studied 100 consecutive admissions to the Hart Island shelter of the New York City Department of Welfare for the month of June, 1952 and 100 consecutive admissions for the month of January, 1953. Some findings of these studies, details of which have not yet been published, are included in the present summary.

¹⁹ The following considerations summarize several studies in which the writer was a participant. Findings are reported in detail elsewhere. See Walcott and Straus, *op. cit.*, Straus and Bacon (1951) *op. cit.*; R. Straus, "Alcohol and the Homeless Man," *Quarterly Journal of Studies on Alcohol*, VII (December, 1946), 360-404; Straus and McCarthy, *op. cit.* Some preliminary suggestions based on data as yet unpublished appear in R. Straus, *Social Stability and Disruption in Alcoholism* (Boston: Massachusetts Department of Public Health, 1953). A comprehensive review of past and present thinking with respect to the homeless man is provided by H. Warren Dunham, *Homeless Men and Their Habitats, A Research Planning Report* (Detroit: Department of Sociology and Anthropology, Wayne University, 1953).

tended to drink at every opportunity and most of the money which they acquired was spent on alcohol.

Data on marital status provide a striking contrast between these two groups. Of the homeless men, a little more than half never married; the rest were either widowed, divorced, or separated from their wives. Among the clinic patients, only 20 per cent had never married; this is to be compared with an expectancy of 21 per cent shown by age-adjusted census data for all urban males. Half of the clinic patients (51 per cent) were married and living with their wives as compared with an expectancy for the total population of about 70 per cent. Among the clinic patients who had married, 36 per cent had become divorced, separated or widowed. This rate greatly exceeds the age-adjusted expectancy of 9 per cent for the total population. But when compared with a marriage fatality rate of 100 per cent for homeless men, the marriage stability of the clinic patients is remarkable.

Records of employment reveal a similarly striking contrast. The homeless men were all without any kind of employment when interviewed. Most had been without a steady job for many years or had never experienced anything but casual employment. Fully half had never held any type of job above the level of unskilled laborer. Only 10 per cent had been employed in white-collar, managerial, or professional jobs.

In contrast, it was found that fully 62 per cent of the clinic patients were steadily employed when first seen in the clinics. Three out of five had histories of steady employment for at least three years. Eighty per cent had records of jobs involving definite status, skills or responsibilities.

Three-fourths of the clinic patients were living in established households; the homeless men obviously had no residential ties. Most of the clinic patients (89 per cent) had lived in their present town of residence for at least two years; the homeless included a large number of transients. The clinic patients were on the whole a much younger group. Nearly half (46 per cent) were under forty years of age; only one out of five was fifty or over. Among the homeless, just the reverse was found—only one out of five was under forty while half were fifty or over.

Although the clinic patients and a majority of the homeless men are appropriately classified as alcoholics,²⁰ it is obvious from the

²⁰ According to the WHO definition.

few data cited here that these groups differ widely in the relative extent to which they have maintained stability in their basic social roles.

The significance of factors of social stability in the therapeutic situation is illustrated by a study made of 474 patients treated in the Blue Hills Hospital of the Connecticut Commission on Alcoholism during the year ending April 15, 1951.²¹ This is a 50-bed hospital operated as an adjunct to the Commission's 6 outpatient clinics. A majority of the patients studied (89 per cent) were referred to the hospital by an outpatient clinic and were discharged back to the outpatient service. Major functions of the hospital are serving patients whose immediate needs cannot be met on an outpatient basis, providing adjunctive types of therapy for which hospital supervision is indicated, helping sustain the therapeutic process when this is threatened by an environmental or emotional crisis, and introducing previously resistant patients to therapy. It was found that the eventual improvement of hospitalized patients was closely correlated with the extent to which patients continued treatment on an outpatient basis following hospitalization. Of those patients who made more than ten followup clinic visits, three out of four showed improvement. On the other hand, of the patients who made fewer than three clinic visits following hospitalization, less than 10 per cent showed any improvement. Improvement judgments were based on a combination of criteria relating the drinking pattern with the development of psychological insight and with factors of social adjustment.²²

In addition to finding a striking relationship between eventual improvement and sustained therapeutic contact, the Blue Hills study revealed that the probability of patients' sustaining therapy was in turn closely related to factors of social stability. The firmer the patient's roots in the community and the more secure his marital and job status, the greater the likelihood that he would be able to follow through with his treatment. In fact, it was found that patients who were both married and employed were exactly twice

²¹ Walcott and Straus, *op. cit.*

²² The man who may have stopped drinking altogether but then become so difficult to live with that his wife left him and he lost his job would certainly not be rated as improved. On the other hand, a patient who had continued to drink would be rated as improved if his drinking pattern showed longer periods of sobriety and if at the same time he was developing insight and was considered an easier person with whom to live and work.

as likely to continue therapy following hospitalization as those who were neither married nor employed.

For homeless men, treatment in an outpatient clinic presents all sorts of difficulties. In most instances they are without any type of permanent tie which would help them sustain contact. The outpatient clinic is severely handicapped in trying to work with such men by the fact that before it can even begin to consider their drinking problem it must try to solve their immediate economic problem—find them a place to sleep and some sort of a job and perhaps clothing. Furthermore, a majority of these men are not motivated towards accepting any “help” with their drinking problem. It was found that when a group of 50 homeless men were offered the services of the Yale Plan Clinic, only 10 were sufficiently interested to make even one visit to the clinic and none continued visits long enough to allow effective diagnosis or treatment. For many of these men the idea of a “clinic”—in a strange setting where people will be well dressed, where there will be close intimate contact with strangers, and where they may be examined and certainly will be questioned—is terribly frightening. They will go to considerable extremes to avoid such a situation.

Differences between clinic patients and homeless men were not restricted to social characteristics. There were also marked variations in the dominant patterns of drinking manifested by these two categories of alcoholic. Clinicians are generally agreed that there is no specific alcoholic archetype. There are so many variables and intangibles involved in the therapeutic situation that each patient must be approached as an individual. The common denominator is the pathological seeking for the effects of alcohol on the nervous system. However, the identification of at least two distinct patterns of alcoholic behavior has emerged independently from several sources. The Subcommittee on Alcoholism of the World Health Organization has suggested that these categories be called “addictive drinkers” and “habitual symptomatic excessive drinkers.”²³

For most addictive drinkers there is an impulsive drive to attain a maximum degree of intoxication from alcohol on nearly every drinking occasion. These people are seeking a peak effect from alcohol which the nonalcoholic has never experienced. Usually, once they start drinking they are unable to control themselves until this peak has been attained. The addictive drinker with a five-dollar bill will probably spend it for some form of beverage which will

²³ World Health Organization, *op. cit.*

provide the greatest amount of alcohol in the quickest and most concentrated form, for in this way he can most successfully raise his level of alcohol blood concentration.

The addictive type of drinking pattern is most characteristic of patients seen in community alcoholism clinics. While there are some addictive drinkers among homeless men, it has been observed that a significant segment of these alcoholics fit the category described by WHO as habitual symptomatic excessive drinkers. They place their greatest emphasis on the duration of their drinking rather than on its intensity. They appear to be seeking a plateau. Given a five-dollar bill these men would not be likely to think how quickly they could achieve a state of peak intoxication, but instead would plan their drinking so that they could maintain a limited level of effect from alcohol for as long a period of time as possible. These plateau drinkers are seeking to maintain a limited alcohol-induced oblivion from the life around them. While under the effect of alcohol the vast gap between their own way of life and the rest of society seems less pronounced. They can acquire a feeling of well-being and accomplishment in the midst of poverty and degradation. They can overlook their lack of material possessions and forget their loneliness. Drinking also provides a certain status in settings where the nondrinker is rare and may even be considered queer and avoided by others.

Most of the homeless men studied do not appear to feel that they have a drinking problem. Many recognize quite frankly that alcohol is providing them with a means of going on from day to day and facing life. About 70 per cent of one group of about 200 men stated with apparent sincerity and frankness that they desired no change in their drinking practices. Change for these men is frightening and full of insecurity and anxiety. The basic problem for a large segment of these men is one of dependency, not alcohol, and it goes far back in their lives.

Half of the men seen in the homeless-man studies had lost one or both parents by death before they reached the age of twenty, and the homes of many of them were disrupted by other factors. Most had left their parental family in their late teens and sought a substitute home in some employment situation providing board and quarters. Some joined one of the peacetime military services or the merchant marine. Not a few served with the Civilian Conservation Corps during the depression of the thirties. In all of these situations they found what can be called a highly institu-

tionalized way of life. That is, the basic necessities of food, clothing, and shelter were provided for them, there was a fairly regular routine, and demands on individual initiative were at a minimum. After a few years of institutionalized living at the crucial age period of perhaps 17 to 24 these men found it difficult to adjust to a more independent mode of living in a community. Having spent a number of years in a protected environment they had failed to learn many of the simple amenities for getting along in a normal society. Even the requirements involved with meeting their basic needs were wrought with insecurity. Furthermore, their contemporaries had married, become regularly employed, developed new interests, and progressed far beyond them. The histories of these men show a procession from one type of institutionalized living to another. Railroad and lumber camps, seasonal agricultural employment, work as attendants in public hospitals, casual laboring jobs in resort areas; all of these situations provided the basic food, clothing, and shelter while demanding little of the individual's initiative. In all of these situations drinking is found as a fairly common form of recreation or adjustment to a dull and isolated level of existence. As incentive diminished and health deteriorated, the men gradually became more dependent on missions or shelters or jails, at first between periods of employment and eventually on a fairly constant basis. The so-called skid row areas of our larger cities actually serve as a form of pseudoinstitutionalized setting for these men. Religious and public charities provide facilities for meeting basic needs, and society puts no demands on its skid row inhabitants. Thus, it is suggested that the homeless man has been caught in a spiral of ever-increasing dependency in which alcoholism of a nonaddictive plateau variety is a form of functional adjustment to his routine and low level of existence. When institutionalized living was studied, the histories of 93 per cent of the homeless group revealed such a pattern; for at least 70 per cent this pattern appeared dominant.

A clarification of differences such as those concerning the drinking patterns of homeless men and the social characteristics of alcoholics coming to community treatment facilities is essential if effective measures to deal with the problems are to be adopted. It is significant that the establishment of clinic facilities has followed recognition of the fact that existing facilities such as jails, shelters, and mental hospitals cannot meet the problem. Then, when the clinics were in operation, it was found that these too do not meet

the problem as it had been defined, but are meeting a previously unrecognized aspect of the problem. Upon further study there followed a reconceptualization of that aspect of the problem particularly concerned with the derelict. Out of this are now developing suggestions for rehabilitation which aim to meet dependency needs as a prerequisite to any shift in drinking pattern.

The few sociological studies of alcoholism which have been reported can be classified into three groups. First, there are those concerned with the phenomenon of Alcoholics Anonymous and its processes of group interaction. Second, there are the studies concerned with identifying segments of the alcoholic population and examining the significance of social criteria in the therapeutic process. Finally, there have been studies of drinking customs.²⁴ These have approached the problems of alcoholism by trying to define the cultural context in which it may appear. Without exception, studies made to date have been suggestive and exploratory in nature. They have helped to narrow the field and provide cues for further study. Although significant progress has been made in providing effective treatment for some alcoholics, real hope for alleviation of the problem appears to lie in prevention rather than cure. In this respect, the sociologist can contribute through investigation of those broader aspects of our culture which breed anxiety, overdependency, insecurity, and feelings of inadequacy in the individual. Alcoholism is but one of many forms of pseudo-adjustment by which certain individuals attempt to overcome unbearable stress and tension stemming from life in their own particular society and culture.

²⁴ In addition, several anthropologists have reported on drinking customs observed in aboriginal cultures. See Ruth Bunzel, "The Role of Alcoholism in Two Central American Cultures," *Psychiatry* III (1940), 361-387; Donald Horton, "The Functions of Alcohol in Primitive Societies: A Cross-Cultural Study," *Quarterly Journal of Studies on Alcohol*, IV (September, 1943), 199-320; George Devereux, "The Function of Alcohol in Mohave Society," *Quarterly Journal of Studies on Alcohol*, IX (September, 1948), 207-251.

The Minnesota Multiphasic Personality Inventory in the Study of Juvenile Delinquents*

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THE RESULTS of one phase of a longitudinal study of some 4,000 young adolescents will be presented in this paper.¹

Early in 1947 the authors designed a project intended to obviate some of the difficulties found in research studies undertaken to reveal how adjusted and maladjusted persons differ in personality characteristics. In general the majority of such studies have tended to relate the background of the deviant or the maladjusted to the personal or behavioral difficulty after his maladjustment has occurred. Thus, much of what is known about the factors supposedly indicative of probable maladjustment is derived from a reconstruction of the developmental histories of deviant persons only. The reliability of such reconstructions is dependent upon a variety of circumstances beyond the control of the investigator and may in part be responsible for the indifferent results achieved when such reconstructed personality and social patterns assumed to be characteristic of deviants are employed to predict the behavior of others believed to be similar to such known deviants.² In view of this it seemed desirable to collect data on the personality and

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¹ The design of the project described in this paper was first reported in Starke R. Hathaway and Elio D. Monachesi, "The Prediction of Juvenile Delinquency Using the Minnesota Multiphasic Personality Inventory," *The American Journal of Psychiatry*, Vol. 108 (1951), pp. 469-473. Some of the more general results of the study are also reported in this article.

² See Lloyd E. Ohlin and Otis Dudley Duncan, "The Efficiency of Predic-

social characteristics of a large group of children most of whom had not as yet manifested gross personality or behavioral disorders. Further, in order to keep at a minimum problems of interpretation and classification of data, it was decided to employ a personality inventory of known reliability and validity to collect personality data. The Minnesota Multiphasic Personality Inventory (MMPI)³ was the instrument chosen. This decision rested on the fact that the published results of research in which the MMPI had been employed suggested that several of the clinical scales contained within it discriminated significantly between male and female delinquents.⁴ A further consideration favoring the use of the MMPI centered on the fact that it could be easily and inexpensively administered to a large sample of children without unduly disrupting a school day routine.

The choice of the population to be studied posed some difficult problems. At first it seemed desirable to concentrate upon one single age group, but the administrative difficulties posed by such a choice were believed to outweigh the advantages to be gained. The inappropriateness of some of the items of the MMPI for very young children suggested the choice of a senior-high-school population; however, the rather abrupt rise in the incidence of juvenile delinquency at approximately the age of 14 years tended to dictate the choice of a younger age group. It was finally decided to study the ninth grade, and so the ninth-grade school children of the public schools of the city of Minneapolis constitute the population of this study.

The MMPI is scored for eight scales that generally refer to the eight more commonly observed clinical syndromes.⁵ These scales

tion in Criminology," *The American Journal of Sociology*, 54 (March, 1949), pp. 441-451.

³ By Starke R. Hathaway and J. Charnley McKinley. Published by the Psychological Corporation, New York.

⁴ Dora F. Capwell, "Personality Patterns of Adolescent Girls: II. Delinquents and Non-delinquents," *Journal of Applied Psychology*, 29 (August, 1945), pp. 289-297. Elio D. Monachesi, "Some Personality Characteristics of Delinquents and Non-delinquents," *Journal of Criminal Law and Criminology*, 38 (January-February, 1948), pp. 487-500. "Personality Characteristics and Socio-Economic Status of Delinquents and Non-delinquents," *Journal of Criminal Law and Criminology*, 40 (January-February, 1950), pp. 570-583. "Personality Characteristics of Institutionalized and Non-Institutionalized Male Delinquents," *Journal of Criminal Law and Criminology*, 41 (July-August, 1950), pp. 167-179.

⁵ For literature on the way the MMPI was developed and standardized, as

measure the similarity, in response to the MMPI items, of the tested subjects to persons clinically diagnosed as afflicted with the emotional and personality disorders suggested by the following scale names: hypochondriasis, (Hs) *; depression (D); hysteria (Hy); psychopathic deviate (Pd); paranoia (Pa); psychasthenia (Pt); schizophrenia (Sc); hypomania (Ma). Scales for measuring social introversion (Sie), masculinity-femininity interests (Mf), are also contained within the Inventory. Four other scales, three of which make possible gauging the validity of the record and one which is essentially a correction employed to sharpen the discriminatory capacity of five clinical scales (Hs, Pd, Pt, Sc, Ma), are also available. The three validating scales are a question score ("?)") consisting of the number of items left unanswered; the L scale designed to measure the degree to which the person falsified his responses in order to place himself in a more favorable position; and an F scale which indicates how careless and uncooperative the subject was in answering the items in the MMPI. The K score, which, as indicated, is employed as a correction, is intended to reveal the degree to which the subject was either overly defensive and evasive or overly self-critical. Elevated scores on either the F and L scales, or on both, cast doubt upon the validity of the entire MMPI record.

The total registration in the ninth grade of the Minneapolis public schools was 4,572 pupils for the year 1947-1948. The testing, which was done by use of the booklet group form of the MMPI containing 550 items, was begun in late 1947 and finished in May, 1948. The number of usable and complete answer sheets produced by this testing program was 4,046. One school refused to co-operate because of objections raised to several items that deal with sexual matters, and 241 pupils were thus lost. Others were lost because of absence from school the day the test was administered, and still others were unavailable because they had dropped out of school during the year. Although every attempt was made to get as many of the ninth-grade pupils as possible, data on only 88.5 per cent of the official ninth-grade registration became available. The group includes 1,994 boys and 2,052 girls.

In January, 1950, an investigation was begun to determine what well as for information regarding the way scores are interpreted the reader is referred to Starke R. Hathaway and J. Charnley McKinley, *Minnesota Multiphasic Personality Inventory Manual*, New York: The Psychological Corporation, Revised edition, 1951.

* Abbreviations of scale names will be used throughout the remainder of this paper.

pupils in the sample had had contact with the Hennepin County Probation Office, the Hennepin County Juvenile Court, and the Juvenile Division of the Minneapolis Police Department. The investigation terminated on July 1, 1950. The search of the records of these official agencies revealed that 597 of the pupils in the sample had been known to the court, the police, or to both. Of this total 442 were boys and 155 were girls, and approximately one-half of the children in each group were court cases. It was found therefore that 22.2 per cent of the boys and 7.6 per cent of the girls had acquired a record with the police, the court, or with both.

Data which indicate how delinquents (referring at this point only to the fact that children so labeled had had contact with the official agencies) differ from nondelinquents are presented in Tables 1 and 2. The data presented in these tables compare the

TABLE 1. NUMBER AND PERCENTAGE OF DELINQUENT AND NONDELINQUENT BOYS WITH SPECIFIC SCALE HIGH POINTS IN THEIR MMPI PROFILES

Scale High Point	Number of Cases for Each Scale High Point (N = 1994)	Number of Delinquents with Each Scale High Point (N = 442)	Percent- age of Those with Each Scale High Point Having Delinquent Record
None	45	4	8.9
?	107	21	19.6
Sie	108	14	13.0
Hs	58	8	13.8
D	79	10	12.6
Hy	51	11	21.6
Pd	411	114	27.7
Mf	102	9	8.8
Pa	59	15	25.4
Pt	115	22	19.1
Sc	279	60	21.5
Ma	420	94	22.4
Invalid	160	60	37.5
Ma Pd *	218	75	34.4
Pd Ma			
Pd' + Ma *	126	53	42.1
Pd Ma'			
Ma' Pd			
Ma Pd'			
Pd' *	186	67	36.0

* Totals of these combinations have already been included in the total N.

† Scale abbreviations followed by the symbol prime (') signify that the standard score on the scale is 70 or more.

TABLE 2. NUMBER AND PERCENTAGE OF DELINQUENT AND NON-DELINQUENT GIRLS WITH SPECIFIC SCALE HIGH POINTS IN THEIR MMPI PROFILES

Scale High Point	Number of Cases for Each Scale High Point (N = 2052)	Number of Delinquents with Each Scale High Point (N = 155)	Percent- age of Those with Each Scale High Point Having Delinquent Record
None	43	0	0.0
>	120	11	9.2
Sie	245	11	4.5
Hs	11	1	9.1
D	15	1	6.7
Hy	57	0	0.0
Pd	381	47	12.3
Mf	346	17	4.9
Pa	136	7	5.1
Pr	85	3	3.5
Sc	157	13	8.3
Ma	350	29	8.3
Invalid	106	15	14.2
Ma Pd *	174	21	12.1
Pd Ma			
Pd' † Ma *	88	14	15.9
Pd Ma'			
Ma' Pd			
Ma Pd'			
Pd' *	149	33	22.1

* Totals of these combinations have already been included in the total N.

† Scale abbreviations followed by the symbol prime (') signify that the standard score on the scale is 70 or more.

two groups on scale high points in the MMPI profiles. As will be noted, not all of the MMPI scales discriminate adequately between delinquents and nondelinquents. It appears that boys (Table 1) whose Pd, Pa, and Ma scale scores constitute the high points in their profiles are delinquent in greater number than those who have other high points in the profiles. Thus approximately one-fourth (25.4 per cent) of the boys whose profiles contained the Pa scale as the high point were delinquent. Profiles of boys with the Pd scale as the high point were delinquents in 27.7 per cent of the cases. Slightly more than one in three (34.4 per cent) boys with profiles in which the Ma and Pd scales constitute the high points

were found delinquent. The association of delinquency with the hypomania and psychopathic deviate syndromes becomes especially marked in cases with standard scores of 70 or more on the Ma and Pd scales. Of all the boys who made scores of 70 or more on the Pd scale 36.0 per cent were delinquent. Among those boys with such high scores on the Ma and/or Pd scales, 42.1 per cent had acquired a record with one or several official agencies. The evidence would seem therefore to indicate that boys who respond to the MMPI as do the hypomanics and psychopathic deviates have some tendency to behave in a manner which is conducive to bringing them to the attention of law-enforcing agencies. None of the other MMPI clinical scales appear to be so closely associated with misconduct.

Of the 160 boys whose profiles were invalid, 60 (37.5 per cent) were delinquent. These findings are in keeping with results obtained in other studies and suggest that unwillingness to be co-operative and truthful in responding to the MMPI tends to be characteristic of delinquents.

The two profile patterns which yield the smallest number of delinquents are those wherein the *Mf* scale constitutes the high profile point and the one in which none of the clinical scales go beyond a standard score of 54. (Category labeled "None" in Tables 1 and 2.)

Comparable data on girls, presented in Table 2, reveal trends somewhat similar to those of boys. Again it is the Pd scale alone or in combination with the Ma scale which shows the closest association with delinquency. Further, none of the girls who achieved profiles with no scale scores greater than 54 had acquired a record with the official agencies studied. The same was found to be true of girls where the MMPI profile high point was the *Hy* scale.

These are some of the more important findings for the sample when profile patterns of children with records and of children with no such records are contrasted. Other interesting results are found when further analyses are made. It is to these results that we now turn.

Scrutiny of the data collected from the files of the official agencies studied (which included such items of information as the nature of the contact, the nature of the offense, the disposition of the case, the date of contact, etc.) suggested the desirability of classifying the children into groups on the basis of the type of misconduct in which the children had engaged or were alleged to have engaged. Three categories of misconduct were created for this purpose:

I. Conduct involving repeated offenses such as automobile theft, burglary, grand larceny, hold-up with a gun, shoplifting, gross immoral behavior (girls), accompanied by less serious offenses. Into this category were placed all children considered as having manifested a fairly well-established delinquent pattern.

II. Conduct involving the commission of only one serious offense such as automobile theft, grand larceny, shoplifting, gross immorality, accompanied by more than one less serious offense such as petty larceny, immoral conduct, disorderly conduct, malicious destruction of property, curfew violation, truancy, and incorrigibility. In this category were placed children who, on the basis of the available evidence, were judged to be not as seriously delinquent as those placed in category I.

III. Conduct involving the commission of such minor offenses as malicious destruction of property as a result of play activities, smoking, drinking, more than one traffic violation, curfew violation, immoral and disorderly conduct. These behavior manifestations were judged as being relatively non-delinquent in contrast to conduct characterizing the other two categories. A review of the available evidence indicated that the majority of children in this last category came into contact with law-enforcing agencies through carelessness, thoughtlessness, and untoward circumstances beyond their control.

No pretense is made that these classificatory categories are rigorous and satisfactorily reliable. They merely represent an attempt to manipulate for purposes of an initial analysis some of the differences in behavior indicated by an examination of the collected data.

A further division of the delinquent group was made. Delinquent children were classified as to whether they had had contact with the police or court before, after, or both before and after, the MMPI was administered.

As indicated above a total of 442 boys and 155 girls in the sample had acquired some record with law-enforcing agencies. The profiles of 60 of these boys were found to be invalid, and 15 of the girls' profiles were also invalid. Children with invalid profiles were excluded from further analyses.

Out of 382 boys with a record, 255 were judged to belong in categories I and II while 127 were placed in category III. One hundred and thirteen of the boys in categories I and II had had contact with the court or police only before the administration of the MMPI, while 108 of the boys in the same categories had such con-

tacts only after the testing program had taken place. Thirty-four boys had contacts with the agencies both before and after the administration of the MMPI. Of the boys placed in category III, 80 had come to the attention of the law-enforcing agencies after testing and 47 had become known to these agencies before their MMPI profiles had been acquired.

Eighty girls were judged to belong in groups I and II, and of these 54 had become known to the police or court only after testing and 26 had become known to these agencies only before testing. Of the 36 girls placed in category III, 22 had contact with the law-enforcing agencies only before testing and 14 only after testing. None of the groups contained girls who had contacts with the agencies both before and after testing. An additional total of 24 girls for whom valid MMPI profiles were obtained could not be classified into conduct categories since their records failed to specify the nature of their offenses, and further inquiry failed to produce information that would permit classification. This group of girls was therefore excluded from any subsequent analyses.

In order to determine which of the scales of the MMPI differentiate significantly between the several categories of delinquents and known nondelinquents in the sample the mean standard scores made on the scales of the MMPI by delinquents and by two groups of nondelinquents were compared. The two groups of nondelinquents consist of 200 boys and 200 girls selected so as to constitute random stratified (on the basis of the number of pupils provided by each school) samples of the entire study population. Every effort was made to include in these two groups children known to have had no contact whatsoever with any public agency dealing with delinquents.

Comparisons of the mean standard scores made by the several categories of delinquents and by the nondelinquent groups indicate that several scales of the MMPI differentiated significantly between delinquents and nondelinquents. (Due to time and space limitations only some results suggestive of general trends of the findings will be presented.) It was found that male delinquents in categories I and II, whose contact with the police or court had occurred only before testing, made significantly higher mean standard scores on the F, Pd, Pa and Sc scales than did male nondelinquents. Tests of significance of differences in means on these scales (t test) indicated such differences to be significant at the 1 per cent level of confidence. It was also found that delinquents in these two

categories made higher mean standard scores on the Ma scale. This difference was found to be significant at the 5 per cent level of confidence. Another scale, the Mf, differentiated between the two groups at the 5 per cent confidence level, and in this instance nondelinquents achieved a higher standard mean score than delinquents. On the basis of these findings it seems reasonable to conclude that male delinquents in categories I and II, whose contact with law-enforcing agencies occurred before the administration of the MMPI, are, in their response to the items of the MMPI, significantly more like clinically diagnosed abnormals of the psychopathic deviate, paranoid, schizophrenic, and hypomanic types than are nondelinquents. Male young adolescents who are nondelinquents seem apt to have more feminine interests than do delinquents.

Somewhat different results are discernible when the mean scores made by male delinquents in groups I and II, whose contacts with the police or court had occurred after, as well as before and after ($N = 142$) testing, are contrasted with the mean score made by male nondelinquents. Male delinquents in these categories made significantly greater mean standard scores (at the 1 per cent level of confidence) on the F, Pd, and Ma scales, while nondelinquents made significantly larger mean scores on the D scale (5 per cent level of confidence) and the Mf scale (1 per cent level of confidence).

Only two scales, the Pd and the Sie, were found to differentiate significantly between male children classified in group III, whose contact with the agencies had occurred before testing, and the nondelinquent group. The "relatively" nondelinquent group made significantly higher mean scores (1 per cent level of confidence) on the Pd scale while nondelinquents made higher mean scores on the Sie scale (1 per cent level of confidence). Children in group III whose contact with the police or court had occurred only after the administration of the MMPI were found to be not at all significantly different from the nondelinquents. None of the scales of the MMPI appear capable of differentiating between these groups. It would seem therefore that with only two exceptions male children placed in what has been termed the relatively nondelinquent category do not differ from nondelinquent males in their response to the MMPI.

The results of comparisons of mean standard scores made by girls in the several delinquent categories and those of nondelinquent girls tend in general to suggest that more scales of the MMPI appear capable of differentiating significantly between delinquents and

nondelinquents. Female delinquents in categories I and II whose contact with the police or court had taken place after the administration of the MMPI made significantly higher mean scores on the F, Pd, Pa, Sc and Ma scales than did nondelinquent females. All of these differences in mean scores were found significant at the 1 per cent level of confidence. Nondelinquent girls achieved significantly larger mean standard scores on the L (5 per cent level of confidence) and the K (1 per cent level of confidence) scales than did delinquents.

Girls whose contact with the agencies had occurred only before testing, and who are classified as belonging in categories I and II, achieved significantly greater scores (at least at the 1 per cent level of confidence) on the F, Pd, Mf and Pa scales than did the nondelinquents. Delinquent girls in these categories also made higher mean scores, significant at the 5 per cent level of confidence, on the Sc, Ma and Sie scales. Again it was found that nondelinquent females made significantly higher mean scores on the K (1 per cent level of confidence) scale.

The only scales which appear to differentiate delinquent girls in category III from nondelinquent girls are the K and F scales. Nondelinquent girls make a significantly higher mean score (1 per cent confidence level) on the K scale than do delinquent girls in category III whose contact with law-enforcing agencies had occurred only before testing. The delinquent girls in group III whose contact with the agencies occurred only after testing made a higher mean score on the F scale, the difference being significant at the 5 per cent confidence level.

It would seem, on the basis of this evidence, that young female delinquents tend on the whole to be marked by personal and emotional difficulties to a more significant extent than young female nondelinquents. This appears to be true if it may be assumed that scores made on the several scales of the MMPI do reflect personality and emotional difficulties.

This first phase of a more comprehensive longitudinal study has made available data that appear to indicate the practicality of employing a relatively easily administered objective personality inventory in order to identify groups of children in schools likely to come in conflict with law-enforcing agencies. It seems presently possible, on the basis of the data available, to indicate that girls in the ninth grade who achieve elevated scores on the F, Pd, Pa, Sc, and Ma scales of the MMPI appear more apt to acquire some record

with law-enforcing agencies than are girls who do not make such scores. The data also suggest that boys who make high scores on the F, Pd, and Ma scales, tend to have a greater proclivity for delinquency than do boys who do not attain such scores. In general it would also seem that children, both female and male, whose MMPI profiles resemble those of patients neurotically depressed, hypochondriacal, or psychasthenic, seem less likely to run afoul of law-enforcing agencies than are children whose profiles are similar to psychotic and psychopathic persons.

These findings, it is believed, can be of utility to all agencies, public or private, whose task it is to prevent the outbreak of serious behavior and personality disorders. The early identification of children who are more prone than others to develop personality and behavior difficulties is a highly important phase of any program designed to prevent if possible, the full development of such difficulties. The findings reported suggest that the MMPI may be employed in the identification of such children.

Psychiatry in Prison

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A PRISON—like other large-scale organizations—reflects in its day-to-day operation many of the unresolved conflicts which exist in the society at large. People in our society are of many minds with regard to the major social problems of our time, of which the treatment of prisoners is one. And the people who work together in the prison and who are charged with the responsibility of guarding and supervising prisoners are not likely to be of one mind simply by virtue of their employment. Thus, controversy continues among those who are concerned with the crime problem, officially or otherwise. Some hold that the convicted criminal must be punished to repay his debt to society. Others believe that he must be rehabilitated and restored as a member of society. The actual treatment of convicted offenders in the prison depends upon the way in which these conflicting views are acted upon by the prison staff; and these actions of the staff become intelligible only if they are viewed in the context of the history of prison reform and with regard to the ideological and psychological involvement of the different professionals who make up the prison staff. The following study examines this involvement primarily with regard to the relation between the staff of the psychiatric ward and that of the custodial division in a state prison.

* Reprinted by permission of the authors and of The William Alanson White Psychiatric Foundation, Inc., from *Psychiatry*, 14 (February, 1951), 73-86. Copyright, 1951, by The William Alanson White Psychiatric Foundation, Inc. This article is the outgrowth of repeated discussions between the authors concerning the interrelations between psychiatric and sociological modes of analysis. When Dr. Powelson served as psychiatrist for three months in the psychiatric ward of a prison, an opportunity presented itself to test our preliminary conclusions by means of case studies. The present article is based on Dr. Powelson's observations, which were corroborated so far as possible by several other psychiatrists who had held the same position, and by Dr. Bendix in a series of interviews with a number of the persons involved.

A criminal's conviction and imprisonment confirm his guilt beyond reasonable doubt in the eyes of most people. Moral condemnation by the public and the authority of government are mutually reinforcing, and in the face of such overwhelming censure it is difficult indeed to take a detached view of the convicted criminal. Since the guilt of the criminal is established, many people feel that most forms of punishment are justified, because public morality has been violated and the authority of the law has been challenged. We shall designate this approach to the criminal as punitive, and we do not subscribe to it. But we must acknowledge at the same time the tragic involvement which tends to make any prison into an institution that creates criminal behavior. In 1935-36, a survey of state prisons showed that 55,822 prisoners out of a total prison population of 106,818 were idle. It is hard to see how rehabilitation is possible under these conditions, but it is easy to see that the unwitting punishment of enforced idleness is likely to have a more corrosive effect on the personality of the prisoner than most forms of deliberate punishment. What we say subsequently concerning the actions and ideas of a prison staff is written in full appreciation of the burden which the setting of prison work imposes upon the members of the staff.

It is perhaps necessary to add a caveat. The prison is a world by itself. Yet, in the prison, each person acts as a member both of the larger society and of the prison society. And the conflicting views of crime and the criminal which prevail in the larger society vitally affect, though frequently in imperceptible ways, the interpersonal relations within the prison. On a routine visit to Condemned Row where every one of the condemned men was locked behind steel bars, except one who was cleaning up, we were warned by the guard, "Do you really want to go in there? It's dangerous!" We feel sure that the guard had a genuine concern for our safety as well as a routine apprehension which is probably second nature to him by now. Yet, in analyzing his behavior, we would feel justified in saying that his warning reflects an exaggerated concern with physical aggression, which is anticipated in all cases but erupts in only a few. We must observe that this anticipation is the basis for a punitive approach to the prisoner. But we realize that basic to this anticipation is concrete experience with aggressive prisoners and the deep anxiety, prevalent among the public at large, which prompts people to identify violent crime with an image of the perpetually aggressive criminal.

In a situation as emotionally charged as that of a prison, every factually accurate observation will be regarded as an attack. A guard who treats an inmate in a punitive way will regard a statement to this effect as a criticism of his action. We have attempted to analyze the perspectives of different members of the prison staff as accurately as we can, but we have no doubt that our observations will be adjudged as partisan by the participants. It is in the nature of conflict situations that any attempt at objective analysis contributes fuel to the fire, and of course no one is entirely free of bias. The analyst is, moreover, not in the role of umpire, since he has usually not been invited to observe.

THE PRISON ORGANIZATION

The Official Training Manual for Correctional Employees issued by the state government contains an historical sketch which is highly instructive. It would appear from this survey that the penal and correctional system of the state has progressed over the last sixty years through the addition of new correctional methods, all of which are designed to strengthen the work of rehabilitation and diminish the merely punitive aspects of the penal system. The following excerpts from this historical account illustrate this point:

- 1893 Parole as a release procedure was adopted. This was an important step away from the classical theory of punishment.
- 1911 State reformatory is authorized. This allowed segregation of younger offenders to prevent further corruption.
- 1917 The indeterminate sentence became law. The arbitrary sentencing power of the judge was removed and the State Board of Prison Directors were authorized to set sentences within minimum and maximum period as prescribed by law.
- 1931 Board of Prison Terms and Paroles was created. This Board had the following duties: (1) Fixing of prison terms to be served; (2) Granting of paroles; (3) Restoration of civil rights.
- 1941 The State Institution for Men was established. It provided a minimum security institution with vocational training and education for younger offenders. This was a major step in the rehabilitation program.
- 1945 Medical Facility authorized. The primary purpose of this institution is to be care and treatment of males who are: mentally ill or defective, epileptic, narcotic addicts, psychopaths and sex offenders.

Under the State Department of Correction and the Chief Warden of the Prison, the following divisions are operating: (1) Guidance Center; (2) Medical Services; (3) Care and Treatment; (4) Business Management and Correctional Industries; (5) Custody. Each of these divisions is staffed with people whose training predisposes them to look at the problems of the prisoners under their care from different points of view. The Official Training Manual for Correctional Employees, in characterizing the functions of these divisions, seems to endorse this professional specialization. A brief review of these divisions may help one to obtain an initial impression of the problems of prison organization.

The Guidance Center is set up so that a "clinical study may be made of each prisoner" which will serve as the basis for "his care, training and employment." The stated objective of the Guidance Center is to reform the prisoner and protect society. The Official Manual, from which this description is taken, also specifies that the work of the center involves the professional services of psychiatrists, physicians, sociologists, psychologists, guidance and vocational counselors.

During his stay in the Guidance Center, the inmate is assigned to work projects and educational programs. This procedure acclimates the new prisoner to institutional living and provides the necessary time for thorough study of the inmate and the planning of his prison program.

It is apparent from these statements of the Official Manual that the professional specialists in the Guidance Center will look at the prisoner from a social welfare point of view. The prisoner is likely to be viewed as a social deviant whose violation of the law is to be attributed to social and psychological causes—such as broken homes, poverty, harmful recreational facilities, difficulties in school, confusion in moral values, and what not. A page and a half of these causes is enumerated in the Manual.

The reform of the prisoner is sought through the care, training, and employment which he receives. The underlying philosophy of the Guidance Center is that a proper diagnosis of the factors which led to the crime will enable the experts to devise a program of activities for each prisoner which will facilitate his rehabilitation. Specifically, his work in the prison will help to reform him and will give him those skills which will enable him, after his release,

to find his place in society. In this way he will lose his criminal tendencies.

The Medical Services in the prison are designed to preserve the health of the prisoner. Specific cases of illness are diagnosed and treated. The sanitation and diet of the prison are supervised, and prisoners are given, when necessary, individual psychiatric treatment. These are the official objectives. They reflect the professional objectives of medicine, which consist in the maintenance of the health of the individual person. Health is the supreme value of the doctor, and that means the health of each person under all circumstances. The supremacy of this value is perhaps indicated by the fact that a prisoner who has been condemned to death and who is at the point of death as the result of a suicide attempt will be restored to health only to be executed. The prison doctor can, therefore, be expected to be concerned with the prisoner as a person whose health is of paramount importance and whose other attributes are consequently of secondary importance.

The Division of Care and Treatment is officially designated as being principally concerned with the prisoner's rehabilitation. Organizationally, this division should execute what the Guidance Center has previously established as in the best interests of the prisoner and of society. Its activities range from education and recreation to the organization of the prison library, religious services, and the parole program. The principal philosophy of this division is that of the educator. Care and Treatment is concerned with implementing the recommendations of the Guidance Center. The prisoner is taught useful skills on the presumption that this will prompt in him the desire to do useful work. It is also done in the belief that his deviant behavior in the past is due in part to the absence of such desires or of such skills. Moreover, the inmate is taught to distinguish between good and bad actions, as these are conventionally conceived. The expectation is that men who know this distinction will act "appropriately," since some of the criminal's behavior is thought to be due to an atrophy of his moral faculties. "A man who knows good will not do wrong."¹

Another division is that of Business Management, which is responsible for the operation and maintenance of the physical plant and for the whole range of industrial operations in which the in-

¹ Quotations not otherwise identified are verbatim statements by members of the prison staff.

mates are employed. Unlike the other divisions which have an ostensibly clear purpose, Business Management faces an inherent contradiction. Businessmen and legislators accept the view that prison industries must not compete with outside industries, but they also accept the view that there is no excuse for an insolvent business operation.

The last division which we consider here is that of Custody. This is the largest division of the prison, in terms of personnel. Its program is officially stated to consist of ". . . the custody and security of the inmates committed to the institutions, and . . . the effective application of rehabilitative measures." If one interpreted this literally, he would expect that the Division of Custody would be independently concerned with all problems affecting security, but that it would follow the direction of the other divisions insofar as the rehabilitation of the inmates is concerned. At any rate, so it would appear from the Official Manual, since the personnel who are expert on problems of rehabilitation are employed in the Guidance Center, the Medical Division, and the Division of Care and Treatment. The historical sketch given earlier would also make it appear that the emphasis on the punitive aspects of the penal system had been left behind. With each addition of services, the correctional features of the prison seem to have gained in importance.

Are these impressions in accord with the facts? The personnel of the Custodial Division is the largest numerically. It comprises some three hundred persons, which is equal to the number of employees in all the other divisions taken together. Although the importance of the different divisions in the prison is not indicated simply by the size of their respective staffs, it would appear that the Custodial Division dominates the operation of all the other divisions. A few illustrations will make this clear. In the Guidance Center extensive records are prepared which give in detail the case history of the inmate and the results of a series of tests which are run by the staff psychologist. The Center's recommendation on the prisoner's program of rehabilitation is based on all these assembled data. However, the personnel of the Guidance Center has no authority over the prisoner once he has passed through these screening procedures. He is then under the authority of Custody. Since his program in the prison is directly determined by Custody, the Guidance Center is only effective in determining the program insofar as Custody is guided by its recommendations. Apparently

Custody is not so guided to any appreciable extent. Our impression is that Custody has a separate and independent system of classifying prisoners which has little, if anything, to do with the recommendations made by the Guidance Center. Each prisoner, who has been classified in the Center on the basis of his case record and a battery of tests, is now reclassified in accordance with Custody's estimate of the prisoner as a security risk. The three degrees of security risk—minimum, medium, and maximum—are only remotely related to these earlier findings. They also have little to do with any objective standard which might enable one to distinguish between prisoners of different degrees of security risk. The custodial classification seems to be based rather on the conventional middle-class evaluation of different crimes. Crimes involving violence, sexual or other, are rated as maximum security risks, despite the fact that murderers and sex offenders have the best parole records. Similarly, former escapees from reform schools never get less than a medium security classification, presumably on the ground that once an escapee, always an escapee. Yet, the individual case might well warrant less severe treatment.

To classify prisoners as Custody does, involves a theory of criminality for which there is no evidence. The theory holds that those who have committed crimes most severely punished in our society are most likely to repeat them and are, therefore, least likely to benefit from the program of the Care and Treatment Division. The facts point to the opposite conclusion, though our knowledge is very limited in this field. Murderers and sex offenders are rarely professionally so, while confidence men, robbers, holdup men, and others are frequently professional criminals and as a consequence are frequent repeaters. While repeated criminal activity does not necessarily mean that the inmate cannot benefit from rehabilitative measures, his chances of benefiting are certainly not better than those of the nonrepeaters. And similarly, the seriousness of a person's crime or the length of his sentence is not a measure of his chances of rehabilitation. This chance can only be judged on the basis of a careful examination of the individual case. The custodial classification, in terms of security risk, is therefore unrelated to the program of correction. It is solely dictated by the consideration that those who have received the highest sentences must be the "most dangerous" to society and the most incorrigible—a view which coincides with that of the sensationalist press. They must be the most severely punished, therefore, not only in

terms of the longer duration of their sentences, but also by the more severe treatment while they are in prison.

Finally, there is the consideration of convenience. Custody supervises the activities of the prisoners and is interested in "smooth operation," regardless of the effect on the individual prisoner. Educational privileges may be extended to inmates as rewards or withdrawn from them as a form of punishment by the custodial personnel. Inmates are assigned to work details under the jurisdiction of Business Management from the point of view of security or convenience. For example, a prisoner who was working as a saw-filer had applied for an assignment in vocational drafting. At the simple request of the custody officer to the Classification Board, the prisoner was kept at saw-filing "because saw-filers are hard to find." The work record may be held for or against the individual inmate and his need or desire for rehabilitation is not considered.²

THE CUSTODIAL ORIENTATION

The only professional group which comes into the prison for positive reasons is that of the custodial employees. They enter the

² We should add that Custody operates in fact on the basis of three criteria: security, convenience, and discipline. What stands for rehabilitative measures in Custody is, in fact, the insistence on conformity and the punishment for breaches of discipline. (It should be emphasized in this context that the number of prisoners is twice the number provided for by the physical plant of the prison; hence the exaggerated concern with security and discipline has an important factual basis.) The maintenance of discipline involves a symbiotic relationship of prisoners and guards which seems primarily based on a system of frames and counterframes. Since guards and prisoners live in close proximity, they become able to obtain favors and inflict harm on each other by means of concealment and denunciation. An obvious example is that guards and prisoners alike prefer some jobs and seek to avoid others. Prisoners compete for jobs by compacts and denunciations. They seek to revenge themselves for ill-treatment and to escape the detection of illicit activities. Guards, on the other hand, depend for the performance of work and for the maintenance of discipline on the prisoners themselves. (The disproportion in the number of guards—*circa* three hundred, as against the number of prisoners, fifty-five hundred—is significant in this respect, since it necessitates a considerable delegation of authority to the latter.) For these and other reasons, the inmates and guards are each vitally interested in knowing what goes on in the other group. The inmates are interested because they may be able to use such knowledge to ease prison life; the guards because their obsessive concern with security makes them suspect the worst of the prisoners and they naturally wish to have the feeling of knowing what the prisoners may

prison with the clear objective of punishing convicted offenders and protecting society. Perhaps members of the other professions (doctors, psychologists, teachers, vocational counsellors, and many others) enter the prison for equally clear reasons, for instance, to promote the rehabilitation and the health of prisoners. Yet, they cannot, in fact, pursue this goal. If, in spite of this, they continue to stay in the prison, it is probable that a number of selective factors enter in which make their continued activity on the prison staff tolerable to them.

There are two principal methods by which the conflict of ostensible goals among the various professional groups on the prison staff could be resolved.³ The first of these methods, and the one which is in closest correspondence with the formal organization of the prison, would be *compromise for the sake of teamwork*. This would mean, for instance, that the health of the individual prisoner is considered paramount whenever this does not conflict with the security of his retention. An example will indicate that such compromises are not made—that, instead, the constant tension that exists between Custody and the Medical Division breaks out into pitched battles on occasion. At one of the psychiatric staff conferences, a number of staff members complained that whenever the inmates applied for psychiatric treatment, the guards addressed them as “ding” or “queer.” Representation against this practice to the Associate Warden, who headed the custodial staff, drew only the reply that this allegation would have to be proved, that none of the guards ever did such a thing, the implication being that the psychiatrists were simply the dupes of malingering prisoners. What is characteristic in this incident is the avoidance of the usual bureaucratic evasion. It would have been easy for the Associate Warden to have stated that this complaint of the Psychiatric Staff would be communicated to the Custodial Staff, although no particular instance of this sort had previously come to his attention.

be about. But of course the concern of the guards with the prisoners is not only punitive, since the latter can frequently render them services. Inside dope is therefore used by both groups as a means of haggling for position.

Temporary participant observation, on which this paper is based, cannot afford more than a glimpse of this system. That it exists became apparent when a sadistic inmate, who would beat up the patients of the psychiatric ward whom he supervised, could not be removed by the head psychiatrist because the Associate Warden was “unable” to effect his transfer.

³ From this point on, our examples will be chosen exclusively from a three months’ observation of the medical and psychiatric division.

This, of course, would have meant no action, just as the real reply did, but it would have preserved the pretense of cooperation. Instead, the representation of the Psychiatric Staff is rejected as unworthy of attention unless it be proved. In that case, the accused guards would have to testify against themselves since the testimony of the inmates is immediately rejected by Custody. It is apparent that the Warden, in charge of Custody, did not consider it necessary to reach an understanding which would be required for effective teamwork. Compromise, then, is not the method usually resorted to in relations between Custody and the staffs of the other divisions.

The formal organization chart indicates the coordinate position of all divisions. Nevertheless, there is hardly any give-and-take between these divisions. In practice, all activities are subordinate to the decisions of Custody, although not directly. Conflicts between the divisions are most frequently resolved by the effective power of Custody over each prisoner. This makes it possible, incidentally, to preserve in many instances the appearance of cooperation even if there is no cooperation in fact. Custody expresses its attitude toward the activities of the other divisions in terms of its actions concerning the prisoner. The other divisions have power over the inmate only when and as long as Custody permits this.

The *authoritarian solution* to the conflicts between the different divisions makes it necessary to characterize their relationship from the vantage point of each. The custodial view of prison organization is in practice that the activities of all other divisions are subordinate to the security regulations and the disciplinary measures of Custody. Custody regards the prisoner, at least unofficially, as a special form of humanity, as a person who must be guilty unless he can prove his innocence. If questioned, most guards are likely to defend this view as proved by the conviction itself. If the inmate were innocent, then he would not be in prison; since he is in prison, he must demonstrate his "reform" by proving his innocence. Hence Custody looks at the activities of the other divisions as evidence of misguided humanitarianism. It will tolerate them only after it is satisfied that every conceivable breach of security and discipline has been guarded against. The guards suspect the other divisions of being "soft." They take pride in their intimate knowledge of the prisoners' depravity as they see it.⁴

Hence the guards will act on the premise that each prisoner is

⁴ We should add, perhaps, that it is quite possible that the expectation of

a cunning malingerer and that each staff member who is not a guard falls an easy prey to the chicanery of the criminal mind. It is as an outgrowth of this orientation that an inmate must convince a guard that he is sick before he can obtain medical or psychiatric attention. But the guard will assume that the inmate is malingering. It is as an outgrowth of the same orientation that Custody acts on purely medical matters in a manner completely unrelated to medicine. The following three examples may show how medical aid to the prisoner is subordinated to the aims of punishment or detection, or is withheld because of the sheer inertia of the Custodial Division.

An inmate who has an ulcer often must first convince a guard that he requires medical help. Once medical tests are positive and the appropriate diets are prescribed, the ulcer patient is put under double lock on order of the medical officer. This means that the prisoner is placed in a regular cell under solitary confinement. Usually he is placed on the most severe diet which can be prescribed for ulcer patients—namely, milk every other hour. However, the patient usually gets milk only three times a day, since the attendants who are responsible for the care of the patient are inmates and are negligent because of ill will towards the patient, or for some other reason. The guards look the other way because they suspect the patient of malingering anyhow. Of course, after a few days of this the patient is so starved that he will do anything to get back into his regular cell although his ulcer is worse as a result of this experience.

A prisoner who had been severely stabbed was bleeding from several deep knife wounds when the doctor arrived. To begin with, the doctor was only asked whether the prisoner was dying; his answer was negative. The prisoner was completely surrounded by guards who questioned him in detail and took photographs of his wounds from various angles. Despite the fact that the prisoner was bleeding acutely, the doctor was allowed to treat the wounds of the patient only after about thirty minutes. The ostensible purpose of this procedure was the detection and punishment of the attacker. It seems then that the doctor

depravity helps to create it. From informal conversation with inmates, one gathers that the obsessive concern of the guards with security makes the prisoners vie with one another in their ability to evade custodial supervision and to do what is forbidden. Obviously, the prisoners evade supervision in order to ease their life in prison, but we would not dismiss the possibility that elements of play—and of playing with danger—enter in. The prison is a dull place to live in; it is overcrowded and time hangs heavy on the hands of many inmates. It is quite possible that the evasion of supervision is also a form of entertainment.

was asked whether the patient was dying—not because his death mattered but merely because the guards wanted to question him. At any rate, it is not apparent why the same questioning could not have been done equally well after the wounds had been dressed.

During off-hours, drugs are not handled by the attendants and registered nurses, but by the guards. The guards are completely unacquainted with the drugs. Some guards carry the drugs all mixed up in a small box and pick out a pill at random when medication is needed. In one case, a patient, who was suffering from excruciating pain, needed a morphine injection. The guard, who brought the patient to the doctor, went to get the morphine capsule. He came back with the capsule in his bare hand, violating the most elementary precautions against infection. The morphine, so obtained, had then to be injected into the arm of the patient. "We have always done it that way" was the only answer the doctor could obtain from the guard.

These illustrations may suffice to indicate the orientation of the Custodial Division. They give a picture of the setting in which the Medical and Psychiatric Division has to do its work.

THE RELATION OF THE PSYCHIATRIC AND THE CUSTODIAL ORIENTATIONS

There is a striking contrast between the custodial and the psychiatric view of the prisoner. Psychiatry, like medicine, is concerned primarily with health. Both are also concerned with the individual and his mental and physical welfare, but here the psychiatric emphasis is the more individualistic of the two. Medicine considers health largely in terms of the community and, in the prison, this is reflected in the medical supervision of sanitation and nutrition for the prison as a whole. Psychiatry, on the other hand, deals only with the mental health of the individual.

Regardless of the current fashion of mental hygiene for whole groups or even nations, the hard fact remains that the whole history of psychiatry and of its therapeutic techniques points to the cure of the individual. This aim of therapy necessitates a thoroughgoing, though not an absolute, ethical relativism. Behavior and emotional disposition are good insofar as they are good for the health of the individual. Psychiatrists are vague enough on what this end-state of mental health is, but they are quite definite in rejecting most of the conventional ethical values as they apply to the individual's attempts at emotional recovery. The prison code re-

gards aggressive behavior as an offense, subject to punishment; yet the psychiatrist will often regard the same behavior as essential for the individual's emotional rehabilitation.

Finally, psychiatrists come into the prison with the belief that the inmate's present action is an outgrowth of his personal history. To the psychiatrist, actions and rationalizations are only the symptoms of underlying causes; hence he will interpret them in this context. To the custodial officer, the inmate's present behavior is the conclusive index of his depravity or of his progressing rehabilitation. How much these views differ is, perhaps, best indicated by the conflict between the custodial and the psychiatric appraisal of the inmate's motivation. Custody thinks of each prisoner as desiring, above all else, to get out of prison by fair means or foul, and so to escape the just punishment of society. Prisoners often present to the psychiatrist a picture of having adjusted to the human jungle of the prison and of fearing the insecurities of the outside world and of their own position in it. Harsh though prison is, it is a knowable world which forces the inmate into an established routine of activities. During the last four weeks before being released on parole, for example, prisoners become tense and are likely to spoil their records. During the period of observation, an inmate was told to clean his cell for the last time within a few hours of his release from the prison. In cleaning his heavy mattress, the inmate dropped it from the height of the fifth tier, seriously injuring another prisoner. After his sentence had been extended by another six years, the inmate showed a notable decrease in tension.

The psychiatrist emphasizes the mental health of the person, the need to consider his present actions as determined by his personal and emotional history, and the need to suspend judgment of the inmate's actions for the sake of therapeutic success. It will be apparent that the prison psychiatrist must come into conflict with the custodial treatment of prisoners if he follows the precepts of his profession. In view of this contradiction, and since there is little effort to minimize it through compromises, it remains for us to show how the subordination of psychiatric to custodial treatment actually transforms psychiatric practice and those who engage in it.

It is apparent that the health of the prisoner, both physical and mental, has become a subordinate consideration under the influence of Custody. Prisoners are well aware that every instance of sickness will be recorded. 'Too many' applications for medical or

psychiatric aid will be held against them, since it will be interpreted as malingering by the custody officer. The medical officer in the prison, therefore, has to deal with patients who have been discouraged from seeking his help. The same subordination of the prisoner's health is in evidence in the procedure of the sick line which forms daily before the prison clinic at a stipulated hour. Those in line have previously persuaded the guard of the validity of their needs, and they presumably consider their complaints serious, since they are likely to have weighed the disadvantage of another sickness notification on their records. Usually they file by the pharmacist who sits behind a small open window prescribing and dealing out drugs as each prisoner states his complaint. There is also a psychiatric sick line, in which patients are seen only for a few minutes at a time. In the clinic a patient may receive a 'complete' neurological and psychiatric work-up in thirty minutes. One psychiatrist has openly boasted to the members of the staff that he can hold 50 'therapy' interviews during the day, and the fact is that he can. Again, when inmates are selected for group therapy, the custodial officer in charge will give the order that all violators of Section 288 of the Penal Code⁵ who are between the ages of 20 and 40 and are nonveterans are to appear for group therapy at a given hour. Thus the physical conditions and the mental climate surrounding medical and psychiatric aid are such as to make ordinary standards of medical and psychiatric practice completely inapplicable.

How can the psychiatric staff do its professional work under these conditions? It seems to us that these are the possibilities:

1. The psychiatrist can become a custody officer and cease all pretense of doing psychiatric work. This is a frequent case in other organizations, as in the case of the professor who has become a university administrator or the medical officer in the army whose duties are administrative and who no longer practices medicine.

2. The psychiatrist may be conscious of a strong antagonism towards Custody; but, in his actual psychiatric work, he adopts Custody's punitive attitude toward the prisoner.

3. The psychiatrist may have a cynical or embittered attitude towards Custody; but, in his actual work, he goes through a routine performance of the job without apparent awareness that

⁵ Provision of the Penal Code providing for the prosecution of "lewd and lascivious conduct."

his work is futile from the psychiatric viewpoint, given the conditions under which it must be done.

4. The psychiatrist may become aware of the irreconcilable conflict between Custody and Psychiatry, and, as a result, leave the prison for practice elsewhere.

The subordination of the particular problems of health and personality to the punitive treatment of the inmate is the condition which Custody imposes on psychiatric practice in prison. The responses of the psychiatrist to this condition reveal much about the interrelation between personality and institutional position.

We wish to comment primarily on the second and third types. The psychiatrists whom we have observed in this situation have in fact abandoned their belief in ethical relativism and psychological determinism. They accept a condition of employment in which concern with the health of the individual inmate can at best be perfunctory. Although they accept Custody's view of the prisoner, they feel constantly challenged by Custody and show a strong antagonism toward it. To illustrate, here is a verbatim record of an interview with a 20-year-old Mexican inmate. The patient is a paranoid schizophrenic who received a one-hundred-percent disability discharge from the Navy and who has been sent to prison with the explicit instruction that he be given psychiatric treatment. The following are some questions put to the prisoner:

"You didn't do well in the Navy, did you? . . . You were mostly unsuccessful all your life! . . . Maybe your illness was caused by taking the money [pension for mental illness]."

(*Then with reference to illness in childhood:*) "Were you able to get out of work when you had an earache?" (*With reference to sibling rivalry:*) "Maybe your brother has tried harder?" (*With reference to a choice the patient had made:*) "You took the easy route again."

(*In response to a blocking of the patient's speech:*) "Go ahead, we can take it." [Whereupon the patient replied: "Yes, you can, but can I?"]

The interview clearly shows that the psychiatrist has abandoned that degree of ethical relativism which is the *sine qua non* of his discipline. The questions put to the prisoner assume that he suffers from moral weakness and that if only he had made up his mind, he would not be where he is now. This is in fact Custody's view. It rests on the idea that the prisoner is a criminal by choice or, perhaps, by virtue of his failure to choose the right way. It is instruc-

tive to hear this view expressed in psychiatric jargon. The following quotation is taken from the instructions which have been prepared for all new members of the psychiatric staff:

The purpose of the Psychiatric Department is first and foremost to safeguard the total, and, especially, the mental health of the individual, to improve the mental hygiene of each and every individual with whom we have contact, be he a civilian employee or be he an inmate. We, therefore, are interested in helping each individual obtain a better understanding of his own thoughts, motives, feelings, and actions, and then help him to help himself to work out a healthy way of living in which he recognizes his basic needs, wishes, and desires, and work out the ways and means by which he can get the most out of life for himself and for his fellow human beings, so that he can earn his livelihood; get his share of love and affection, his share of friends and learn to work out his own problems a little bit better each day.

It is our desire and purpose and aim to help each man to organize and balance his personality so that he will have a reasonable goal or ambition in life with short term and long term goals in keeping with his assets and capacities, handicaps and opportunities. We want each man to use his intelligence and his judgment to plan ahead with imagination and vision and, at the same time, temper his plans and his imagination and his prayers with reality. It is our aim to help each person develop a true appreciation of the value of time and plan and ration it accordingly; to develop in each individual a skill, or trade, or vocation by which to serve his fellow human beings better—to use sufficient initiative to even develop an avocation or a craft or a spare time interest or hobby. . . .

We hope to help those with whom we work to develop a balance between present pleasure and future needs; to develop good habits—physically, mentally, and emotionally; to use drugs and alcohol only with judgment and understanding. We bend our efforts to fully develop, in ourselves and others, reliability and dependability and responsibility; to develop understanding of emotions and emotional instability and controls of these emotions and their variations; to develop an appreciation of the value of personal and social contacts and so train ourselves to be good friends as well as to deserve good friends—to learn not only the cause of our emotional swings but that we all have moods and that a certain amount of control needs to be exercised in or over our moods.

We all need self satisfaction points of rest and recreation, of play, hobbies, new experiences.

We all have sex needs and we should realize that the ultimate goal of sex needs is the formation of the family. We endeavor to train ourselves to understand our psychosexual development and, when com-

promises are made, that they be recognized as such. We all need to learn to solve our problems without too much tension, evasion or frustration, and we all need to develop a personal philosophy of life; to learn to Live and Let Live—not to get too upset when things go wrong or too self-sympathetic when things don't turn out as we plan. . . .

Let us, therefore, point every effort to not only understanding ourselves better and training ourselves to develop a healthy way of living; to train ourselves to daily live a healthy personal religion based on the understanding and gaining for ourselves and other fellow human beings the most life has to offer, legitimately.

Let us continue our search for the truth that sets us free in mind and body and help our fellow human beings by giving them a little more of the light that we have been fortunate enough to get ourselves.

The view here expressed might be taken from an after-dinner speech on mental health to any fraternal organization. It endorses the custodial view that the depraved prisoner must be rehabilitated by being confronted with a model of the "clean life." The prisoner must be taught to cherish the values of the family and of "the good deed." He must also be taught never to want more out of life than he can get. In this context, the prisoner, far from being told of the virtues of striving, shall be advised by the psychiatrist that above all he should exercise moderation and self-restraint. The values stated in the Instruction Manual are such that no prisoner could live up to them, if for no other reason than that he is in prison. Witness, for instance, the statement that "the ultimate goal of sex needs is the formation of the family." A prisoner's failure to "adjust" and to "reform" is evidence of his moral inferiority. In the light of the views expressed in the Manual, it is hardly surprising that psychiatry in the prison consists primarily in therapeutic practices which can have punitive or disciplinary implications: electric shock, insulin shock, fever treatment, hydrotherapy, amyral and pentothal interviews, cisternals and spinals, and so on—that is, everything except psychotherapy.

Under the conditions extant in the prison, this conventional and punitive approach to the prisoner will eventually determine the practice and personnel of the ward. This approach to the prisoner requires of the psychiatrist a rigidly prescribed range of behavior. The personality attributes which would permit a person to function effectively under these conditions have been well summarized by A. H. Maslow, who lists the traits which are characteristic of an authoritarian personality. He is a person who looks at the world

as a jungle "in which [each] man's hand is necessarily against every other man's, in which the whole world is conceived of as dangerous, threatening, or at least challenging, and in which human beings are conceived of as primarily selfish, or evil or stupid." ⁶ Such a person has a tendency to view others as superior and therefore to be feared; or as inferior and therefore to be scorned. He tends to have a strong drive for power and for external prestige. Kindness is identified with weakness, and hardness with strength. The sadistic component of his personality is likely to be prominent in his relations to the prisoners, while the sado-masochistic component appears in the relation among staff members. He achieves a superficial feeling of security through compulsive routines, order, discipline, and rigidity. It is a fair guess that these same character traits would be a liability rather than an asset in any extended period of contact between patient and therapist, and as a result very considerable anxiety would be generated in both participants. Moreover, such a doctor might find it very anxiety-provoking to associate with other psychiatrists. Hence, he would experience great insecurity outside the prison; but inside the prison the situation is different. We stated earlier that the custody officers come to their work in the prison for positive reasons. We should now amend this by stating that a psychiatrist of the type we have described would take on a prison job, such as we have described it, for equally positive reasons. The very personality characteristics which are liabilities in outside practice turn into assets in a prison of this kind.

A person of this type is best able to function simultaneously on these five levels: (1) He is antagonistic toward Custody and its encroachments. (2) As opposed to Custody, he gives lip service to the importance of psychiatric treatment. (3) In his psychiatric practice he shows the same attitude toward the prisoner as the guards do. (4) He is only conscious of doing expert psychiatric work and indeed prides himself in being part of a model department. (5) He is conscious of custodial interference but unconscious that he, basically, agrees with the attitude towards the prisoners which lies back of this interference.

It is apparent that a psychiatrist of such disposition is able to tolerate the wide gulf between the stated aims and the actual practice of psychiatry in the prison. Psychologically, this is most toler-

⁶ A. H. Maslow, "The Authoritarian Character Structure," *J. Social Psychol.* (1943) 18:402.

able because he has actually adopted the custodial view, although he would, of course, deny this vehemently. He is unconsciously at peace, as it were, though at the conscious level he fights a running battle with the other divisions. And he is able to do this effectively because he can perform each of his incompatible roles in isolation from the other or reconcile them by projecting his internal conflicts on others.⁷

Psychiatrists of less compulsive and sadistic disposition cannot make this adjustment. They will either keep their antagonism toward Custody and their routine psychiatric practice in separate compartments—though the custodial environment makes that practice well-nigh meaningless, or they will become so intensely conscious of the conflict that they will leave the prison because they are unable to tolerate it in any form. The net result will be that the personnel of the psychiatric service will become typed, because, by a gradual process of attrition, those who do not fit in will be eliminated and those who do fit in will stay on. Our period of observation was, of course, too short to see this process in operation, but, on the face of it, it is probable that persons of the personality type we have described will unwittingly help to perpetuate this pattern of character structure and institutional position. In selecting additional personnel, such persons will tend to favor persons like themselves and, in organizing the psychiatric department, they will create conditions sufficiently uncongenial for persons of other types.

CONCLUSIONS

It may be useful to summarize the major conclusions of this study by an explicit statement of the frame of reference on which it is based. We began our observations with the finding that psychiatry, as practiced in the prison, was unlike psychiatric practice in any other context with which we are familiar. This finding pointed to the different views of punishment, rehabilitation, and criminal behavior, as these are institutionalized in the different divisions of the prison. It also pointed to the different historical background of the various professions represented in these divisions. Retention and punishment of convicted criminals is one of the major prob-

⁷ It should be added that psychiatrists also function in a custodial capacity. They sit on the Disciplinary Committee and they do medical examinations, which serve detective functions, at the request of Custody.

lems of modern society. The prison brings to sharp focus all of the conflicting views concerning this problem. These conflicts are resolved, after a fashion, in the institutionalized interplay of the professions which represent these views on the outside.

The history of institutional changes.—In this field as in others, the history of institutional changes is frequently presented in the form of dated events. In 1893, parole as a release procedure was adopted; in 1911, younger offenders were segregated from older offenders, and so on. Those who espouse the cause of penal reform are likely to take more solace than they should from the apparent progress which has been made. Their concern with legal reform is certainly legitimate, but they tend to overlook that even explicit adoption of these reforms in penal institutions is not an indication of their effect on practical application. The history of dated events is a surface phenomenon.

Formal organization as an ideology.—It is odd that the reformer is aided and abetted in this deception by those who stand against reform. We have tried to show how the general trend toward penal reform is reflected in the formal organization of the prison. But we have also pointed out that the formal endorsement of correctional, rather than punitive, penology is not acted upon. Formally, each of the divisions has its assigned role in effecting the rehabilitation of the inmate, and rehabilitation is clearly the stated aim of the prison. In fact, Custody prevails, and, with it, the punitive approach to the prisoner. The challenges to this approach have been enacted into law and the letter of the law has been followed; but the effect has been to create a prison in which the inmate is subjected to punitive practices which are represented as designed for his rehabilitation. We are observers, not judges, of this system and we lack the experience required for remedial proposals.⁸ But at least it is an open question whether an admittedly punitive treatment of the prisoner might not be preferable to a punitive treatment under the pretense of rehabilitation. This is not an argument for punishment, but, rather, an argument against the false representation of whatever treatment is adopted. The criminal, as a human being, is likely to benefit from a clear statement of purpose corresponding to practice, whether that purpose is punishment or rehabilitation.

⁸ As an example of possible solutions, we might mention one which has passed the stage of advocacy and is in the process of becoming fact: that for psychiatric disorders prisoners be placed in a prison where the warden is a psychiatrist.

Obstacles to institutional change.—Institutional changes cannot be effected by gradual accretions. The addition of guidance centers and psychiatric services is necessary but hardly sufficient. These additions will be largely futile so long as the Custodial Division is not completely reorganized, both in the training program for correctional employees and, above all, in the supervisory practices on the job. Yet, a better supervision of guards on the job would encounter a seemingly insurmountable obstacle. This is, perhaps, responsible for the tremendous difficulties which stand in the way of reform. The guards are the disciplinarians of the inmates. They have the responsibility for security as well as for the adherence to prison regulations. If the guards were supervised, the inmate would become aware of the fact that their authority over him is not final. Of course, this is, in principle, true of all strictly authoritarian organizations, though in most of them, including the prison, there are some provisions for complaint; but in the prison the guard's authority is represented to himself and to the inmate as the symbol of just punishment. The guard must be obeyed because the conviction has subjected the morally delinquent inmate to his authority. The moral rightness of authority is called into question when a supervisor can correct a guard's decision. The moral depravity of the prisoner becomes, therefore, an assumption which is necessary for the self-esteem of the guard, because it implies that his authority is symbolic of justice, regardless of how he exercises it. It is apparent that supervision of the guards would jeopardize this system of interlocking assumptions, since a check on the guard's authority over the prisoner seems to challenge the justice of the punishment itself.

It seems to us that vague feelings of this kind lie behind the behavior of custodial employees. In observing the conflicting ideas about prisoners and punishment which are embodied in the divisions of the prison, it is essential to view the activities of each of these as seen by the personnel themselves. This enables the observer to assess the momentum which lies behind the patent discrepancy between formal role and the actual behavior of the individual employees within the organization. To understand how each group looks at its own performance, it is helpful to consider the history and ideology of the profession which it represents. But it is also necessary to consider the situational pressures within the organization. In this instance, these pressures result from the moral gulf which is conventionally assumed to exist between the criminal and

the guard. Nothing a prisoner does is ever unequivocally right. His rehabilitation, however, would require many actions which would have to be considered right. Hence, rehabilitation tends to threaten the view that the inmate is a depraved individual whose every action confirms this depravity. On the other hand, there are few actions of the guard which are unequivocally wrong, unless it is a violation of the law which cannot be overlooked. To think that a guard's action might be wrong is to challenge the justice of the punishment and of those who administer it.

The rehabilitation of the prisoner is not likely to succeed so long as these views prevail. Rehabilitation would seem to depend on the willingness of the guards to see their exercise of authority criticized. And this willingness depends, in turn, on the belief that criminal tendencies exist in all men, including one's self.*

Personality and institutional position.—The prison as an institution does not have an organizational purpose other than the purpose enacted into law. The prison is staffed by a variety of personnel. Each person, as well as each group of persons, performs his duties in terms of formally articulated goals. These are not the same as a person's motive in taking the job. Rather, each will seek to rationalize his activities within the organization in terms of "what is good for the institution" as his professional training and personal disposition prompt him to see it. In doing that, he will encounter the competing rationalizations of others. He will come to terms with the discrepancies between what he does, what he claims to do, and what his profession stands for ideologically. In some measure, this is true of any of the different departments in any organization. It is highlighted in this institution by the striking incompatibilities between psychiatric practice and practice on the psychiatric ward. It illustrates a very frequent source of tension in modern society in which a large number of people work in large-scale organizations and are, thereby, exposed to similar strains. But the prison we have examined is striking in that the internal pressures of prison organization make for a closer fit between personality type and institutional position than is likely to be true of less extreme instances. These internal pressures will help to make psychiatrists of a different bent ineffective or to eliminate

* In this connection it would be worth while to make a systematic study of the social and psychological characteristics of the attendants, orderlies, or guards who have the most frequent contact with the patients or inmates in mental and correctional institutions.

them. On the other hand, psychiatrists who have authoritarian tendencies will show an "elective affinity"¹⁰ for work which turns these tendencies into personal and institutional assets.

¹⁰ Max Weber has used this term in his psychological analysis of religion. See *From Max Weber: Essays in Sociology*; translated, edited, and with an introduction by H. H. Gerth and C. Wright Mills; New York, Oxford Univ. Press, 1946; pp. 284-288. Cf. also the illuminating comments by the editors in their introduction, pp. 62-63.

SECTION VII

Contributions to the Understanding of Mental Health

THIRTY-TWO

Changing Ideas on Mental Illness and Its Treatment*

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SOCIAL scientists sometimes get a mite discouraged over the slowness of the public to accept their findings. The folklore is tough and resistant, entrenched in "common sense" and bulwarked by dogmas concerning the nature of human nature. To substitute the viewpoints derived from scientific research seems a slow process.

However slow the process may be, it does eventually become apparent that the folklore is yielding in many areas. This paper presents some evidence that it is being overcome in the particular area having to do with mental illness and personal maladjustment. Folk beliefs concerning causes of mental disorder, folk attitudes toward the victims of such disorder, and folk prescriptions for treatment are all giving way to concepts and attitudes based on modern science. The change in a generation is really surprising, and should hearten the sociologists, the social workers, and the psychiatrists. This at least is the conclusion to be drawn from the research study about to be described.

In the summer of 1950 *Collier's Magazine* and the City of Louisville jointly agreed to finance a study of the attitudes of Louisville

* From *American Sociological Review*, 16 (August, 1951), 433-454. Reprinted by permission of the publisher.

citizens on the general subject of mental health.¹ The study was one of a series carried out by the firm of Elmo Roper at the behest of Mayor Farnsley of Louisville and generally designed to make citizens articulate with respect to the problems facing municipal administration.² In the mental health survey a cross-section sample of 3971 Louisville residents 18 years of age and over were personally interviewed in their homes by Roper interviewers. Interviewing took place in all the odd-numbered census tracts (44 in all) with quotas proportional in each case to the population of the tract. Within the tract the interviewer followed a prescribed route on a map designed to cover most of the tract area. She interviewed in pre-designated dwelling units, but could substitute the adjacent unit after one unfruitful call. Sex and age controls based on census estimates were used within each tract.

It is impossible within the confines of one article to report on all the questions asked respondents.³ The writer will have to be content with stating some general findings and supporting each with one or more bits of evidence from the study. Care will be taken to avoid stating conclusions where all the data do not point in the same direction. Inevitably there were some inconsistencies in the results from different questions. In the first place, people's attitudes are not necessarily consistent in areas where their knowledge is limited (nor in fact even where they are well informed). In the second place, there is always some error in measuring attitudes through the medium of questioning in a public opinion poll. But there was enough consistency to make certain conclusions fairly clear-cut and demonstratable.

I

The first major conclusion that emerges from an analysis of the study results is that people (at least in Louisville) are definitely moving toward a humanitarian and scientific point of view toward

¹ The committee in charge of the design of the project included Elmo Roper, Lawrence K. Frank, Dr. John Spiegel, Dr. William Keller, Charles Farnsley, Albert Maisel, and the writer.

² Julian L. Woodward and Alan Schneider, "What do the Citizens Think?" *National Municipal Review*, 39 (June 1950), 288-292.

³ A complete set of tables is provided in Elmo Roper, *People's Attitudes Concerning Mental Health*, New York, 1950. This document is unpublished but a limited number of copies are available for distribution to interested individuals and organizations.

mental illness, and have come quite a long way in that direction. The old ideas that the mentally ill were bad and dangerous, and hence to be punished (on the one hand) or were ludicrous and silly, and hence to be laughed at (on the other) seem to be to a considerable extent superseded by the feeling that mental illness is a sickness that should evoke sympathetic understanding and that requires some form of professional treatment.

The general pattern of answers in the study as a whole is the best support for these conclusions, and the age breakdowns on nearly all of the questions show a clear-cut differential between the old and the young, with the latter uniformly the more "humanitarian." The young are also nearly always more "scientific" in viewpoint in the sense that they more often favor calling in professional help and are more attuned to modern sociological concepts of group therapy. The same contrasts appear in the breakdowns by education. Taken together the analyses of responses by age and education of respondent provide convincing evidence of social change.

Tables 1, 2, and 3 provide good illustrations of the changes in attitude that have been occurring. A majority of people now doubt that "most mental illness is inherited," but there are fewer believers in the dogma of inherited taint among the young than among the old. The myth that "most hospitals for the mentally ill treat their patients very badly" is also rejected by a plurality of those with opinions, but the young age groups are somewhat more certain that the statement is on the whole an untrue one.⁴

The fact that the majority of Louisville citizens feel that there are not enough doctors and hospitals in the city to give proper care and treatment for the mentally ill is perhaps also an indication of growing sophistication. Younger and better educated⁵ people were more likely to hold this view and they were also much more likely to express the belief that the place for a sex criminal was a hospital rather than a jail. That 61% of the total Louisville sample favored hospital treatment for the sex criminal is the more surprising because a lurid sex crime had been on the Louisville newspaper front pages during the week preceding the interviews.

Finally there is evidence in Table 3 that the sense of stigma as-

⁴ Age breakdowns are shown in the Tables only for males, to save space, but the female breakdowns were always similar in trend to those for males.

⁵ 72% of college-educated people voted the statement true as against 67% of those with high school education and 61% of those who did not go beyond grade school.

TABLE 1

Question: "There are all sorts of opinions about mental illness and what causes it. I'm going to read you some statements on which people differ and ask you to tell me whether you think they are more true than false, or more false than true."

No. of Respondents	Total Sample	Total Males	Males Whose Ages Are			
			18-24	25-44	45-64	65 and Over
	3971	1839	260	842	543	188
Per Cent Distribution of Replies						
Statement: "Most mental illness is inherited."						
False	72	71	75	77	65	52
True	16	19	18	16	21	29
Don't know	12	10	7	7	14	19
Statement: "Most hospitals for the mentally ill treat their patients very badly."						
False	46	49	57	53	44	34
True	22	22	20	21	27	20
Don't know	32	29	23	26	29	46
Statement: "There are not enough doctors and hospitals in Louisville to give proper care and treatment to all people who are mentally ill today."						
False	23	25	30	25	22	24
True	64	64	60	67	65	59
Don't know	13	11	10	8	13	17

TABLE 2

Question: "Which do you think is the best thing to do with sex criminals, send them to a hospital or a jail?"

	Per Cent Distribution of Replies								
	Education (Both Sexes)				Age (Males Only)				
	Total Sample	8th Grade or Less	High School	College	Total Males	18-24	25-44	45-64	65 & Over
Hospital	61	55	66	74	59	74	66	49	40
Jail	23	28	21	15	25	17	21	31	37
Other (volunteered answers)	8	9	8	7	9	4	8	12	10
Don't know	8	8	5	4	7	5	5	8	13

TABLE 3

Question: "Suppose a member of your family became mentally ill. Do you think you would tell your friends and acquaintances about it just as if he had heart trouble or asthma, or would you try to keep it as quiet as possible?"

	Per Cent Distribution of Replies								
	Education (Both Sexes)				Age (Males Only)				
	Total Sample	8th Grade or Less	High School	College	Total Males	18-24	25-44	45-64	65 & Over
Tell it to friends	44	42	45	50	41	44	44	39	34
Keep quiet	47	50	46	45	50	47	47	53	54
Don't know and No Answer	9	8	9	5	9	9	9	8	12

sociated with mental illness is passing. About half of the Louisville citizens interviewed say they would not hesitate to tell friends and acquaintances about a family member who was mentally ill "just as if he had heart trouble or asthma." Faced with an actual situation not all these people would be as frank and revealing, nevertheless the expression of opinion is significant. It is especially so because of the age and education differences in response that are revealed in the Table. These differences are not as great as those on other questions—this is a question which strikes home and people are often more conservative about themselves than about others. But the indicated direction of change is toward a more rational and scientific viewpoint.

II

There were two case descriptions presented to respondents in the study in which a pattern of symptoms was described that an expert would recognize as strongly pointing to probable psychosis. How did respondents react when asked to suggest "what should be done" about these two subjects?

As a preliminary to discussing the cases individually one may make four generalizations that apply fairly well to both of them. It may be said (1) that there was a probable failure on the part of a large share of the respondents to recognize how seriously ill and in need of expert help the two subjects were. In spite of this there was (2) a substantial number of respondents who suggested some

form of "scientific" treatment, usually referral to psychiatrist or physician. Somewhat overtopping the "scientific" group was (3) a group favoring what might be called a "common-sense humanitarian" (but not scientific) approach. The size of this latter group is no doubt influenced by a failure to diagnose the need for professional treatment, by lack of knowledge of the existence of such treatment, and by doubts concerning its efficacy. Finally, as a fourth generalization, it should be noted that any punitive or "disgracing" treatment technique is in extremely low favor. This fact would also be more significant if the cases had been regarded as more serious.

Turn now to the first of the two cases for evidence to support these generalizations. The lady described in the question in Table 4 is a paranoid type clearly in need of professional treatment, and she may conceivably become dangerous to her neighbors if it is too long delayed. When read the case description and asked the open question, "What do you think ought to be done about Mrs. B?" less than 2% said, "Have her arrested," less than 1% suggested physical punishment, and 1% wanted her put away in a mental hospital. On the other hand 20% said, "Take her to a psychiatrist," and another 13% said, "Take her to a doctor."

Commonsense-humanitarian techniques were also popular. Fifteen per cent advised, "Talking it out and convincing her she is wrong," and 7% said, "Show her more love and understanding." When all the commonsense "home treatment" suggestions (Talk it out, get help from religion, "ignore her," show her more love, change her environment) are totalled, they bulk slightly larger than the "scientific-treatment" suggestions. Twenty-five per cent of the respondents would make no suggestions whatever on what should be done with Mrs. B.

When respondents were given a list of possible "things to do" about Mrs. B (see Table 4) and asked to say which one they thought would be best, the drastic, protective-punitive actions (lock her up, put her away in a mental hospital) found little favor. More than half of the people picked the alternative: "The police should be called immediately to lock up Mrs. B until she calms down" as the *worst* thing to do under the circumstances. Whether this unwillingness to put Mrs. B away was due to a failure to recognize her as really queer or dangerous or whether there was a complete loss of faith in the old protective approach to mental disorder is of course a question. The total pattern of evidence in

TABLE 4

Question: "Mrs. B had always been a little suspicious and inclined to take the worst view of things, but she had led a fairly happy married life until she began to accuse her husband of not loving her any more. When she saw him speak politely to an attractive widow next door, Mrs. B waited until he had left, got hold of his gun, and then went over and threatened to kill the widow. Mrs. B's husband hadn't done anything wrong and doesn't know what to do about her.

"Here are some things various people have suggested might be done about Mrs. B. If only one thing on the list could be done, which one do you think it would be best to do?" (Card shown respondent)

	Per Cent Distribution of Replies					
	Total Sample	Total Males	Males Whose Ages Are			
			18-24	25-44	45-64	65 and Over
Her minister or priest should be called in to talk with her	26	25	23	25	26	25
The husband should give her a good talking to and then wait to see if her jealousy won't blow over	21	23	34	23	18	19
The family doctor should be called to see if he can't give her something to calm her nerves	21	19	11	27	19	17
The husband should stay home with his wife to prove to her he really loves her	13	13	17	12	15	11
She should be taken to a mental hospital where she can be treated and where she can't harm anyone	7	7	5	7	7	6
The police should be called immediately to lock up Mrs. B until she calms down	1	1	1	1	2	2
None of them or Don't know	11	13	10	11	13	20

the study would indicate that there was some of both types of thinking involved, as well as a strong disinclination to bring disgrace on anyone unless absolutely necessary.

As between the commonsense home-treatment approach to Mrs. B's case and the scientific-professional approach the results are clear-cut only in showing that both are preferred to the protective-punitive. Resort to the "minister or priest" was the most favored alternative and he is evidently regarded as a person to turn to in trouble. Nowadays he is more likely to have enough training to recognize a psychotic when he sees one, and to pass Mrs. B on to a psychiatrist. The same may be true of the family doctor. There is, however, a willingness on the part of a good many respondents to prescribe their own treatment for Mrs. B, presumably in terms of their own experience in human relations. Some 21% favor fairly drastic action by the husband in disciplining his wife by "giving her a good talking to" (the women are for this almost as often as the men). A smaller group (13%) think he ought to stay home more and prove that she is his major object of affection.

Much the same conclusions may be drawn from the case of Mr. G (see Table 5), a depressive, only here there is apparently less recognition of the need for professional treatment and more tendency to rely on kindness and commonsense. He should be given encouragement and understanding from family and friends; "someone" should get him a new job; he ought to "pull himself together" (lift himself by his bootstraps!) and find a new job for himself; he should have a rest or vacation; he should find some kind of distraction—a hobby perhaps or at any rate "something to do." These are the sorts of suggestions that respondents make frequently when asked the open question, "What do you think ought to be done about Mr. G?" Only 9% spontaneously suggest that he see a psychiatrist, an additional 8% recommend a doctor, and 6% propose "religious therapy" ("He needs more faith in God and prayer") through a minister or priest.

When the alternatives are organized for the respondent (Table 5) the results are not very different. Even when psychiatric treatment is specifically suggested it gets only 11% of the first choices (this rises to 24% among the college-educated). The field so far as Mr. G is concerned still largely belongs to lay diagnosis and commonsense. Of course a potential suicidal is not dangerous, and is a natural object of pity and a prime candidate for Christian charity and helpfulness. Perhaps it is a mark of progress that as

TABLE 5

Question: "The last person I want to tell you about is Mr. G, a 52 year-old machinist. Mr. G had always been a hard worker who had worried a lot about making both ends meet for his large family. One day his job at the plant was given to someone else and he was told by his employer that he was no longer needed. After this happened, he became very depressed, accused himself of being a complete failure, and worthless to his family. He refused to look for another job or take an interest in anything and finally tried to commit suicide.

"Here are some things various people have suggested might be done about Mr. G. If only one thing on the list could be done, which one do you think it would be best to do?"

No. of Respondents	Total Sample	Total Males	Males Whose Ages Are			
			18-24	25-44	45-64	65 and Over
	3971	1839	260	842	543	188
Per Cent Distribution of Replies						
His family and friends should give him a good pep talk and urge him to look for another job	33	34	41	35	29	32
He should go to his family doctor to find out if there is a physical illness that is causing him to feel badly	16	15	12	16	16	16
He should have a good long rest away from his family responsibilities and worries	15	15	17	15	15	11
He should be given plenty of time to recover from the shock of losing his job and then he'll be all right again	14	12	10	11	14	11
He should be sent to a psychiatrist for consultation and treatment	11	12	12	14	10	5
He should be sent to a mental hospital or asylum until he is better	2	3	1	2	3	6
None of them or Don't know	9	9	7	7	13	19

many as 11% of the people of Louisville recognize that Mr. G is a mental case of sorts, and that someone called a psychiatrist might be more helpful than a pep talk or "long rest" in effecting a cure.

III

The tendency to abandon repression and incarceration as treatments and to substitute more humanitarian and "scientific" techniques is especially exemplified in the case of the juvenile delinquent included in the study (Table 6). Here the sociologists and social workers seem to have really made a good start in selling the

TABLE 6

Question: *"I'd like to ask you a question about a fifteen-year-old boy who has been in trouble repeatedly for staying away from school and has recently stolen an automobile."*

"Here are some things various people have suggested might be done about this boy. If only one thing on the list could be done, which one do you think it would be best to do?"

	Total Sample	Total Males	Per Cent Distribution of Replies			
			Males Whose Ages Are			
			18-24	25-44	45-64	65 and Over
See to it that he joins a boys' club and is encouraged in sports and other worthwhile activities	55	52	63	56	49	36
Have a psychiatrist find out why he behaves this way and then try to change his attitudes and behavior	25	22	23	25	21	12
Put him on juvenile probation and have a probation officer check up on him frequently	7	9	6	8	10	11
Send him away to a reformatory like Greendale	4	5	3	2	7	13
Have his father give him a good old-fashioned whipping	3	4	1	3	4	10
Punish his parents by sending them to jail if he does anything else that's bad	1	2	0	1	3	4
None of them or Don't know	6	6	4	5	6	14

public on their point of view concerning the treatment of juvenile crime. When asked the open question on what ought to be done about the fifteen-year-old truant and automobile stealer the most frequent responses are of the repressive type (punish him, send him to a reform school). But the minute the boy's club is suggested to them as one of six possible courses of action (Table 6) it commands clear majority support. The reformatory and the "old-fashioned whipping" retreat almost to the bottom of the list, behind juvenile probation and referral to a psychiatrist. And re-examination of the open-ended question answers indicates that while punishment and the reform school get the most spontaneous votes and head the list, the actual number of votes for more modern techniques, when all the different categories are added together, overtop those going to traditional repression.

The people who oppose repression have good reasons for their attitude, good at least from the sociologist's point of view. Those who think that whipping is the worst of the six alternatives say simply that a hiding would arouse vindictive feelings in the youngster and would lead to more of the same behavior—it would do no good and simply make him worse. Those who are against reform school emphasize especially the bad associations there, using such phraseology as the following to describe their feelings: "He would be with bad companions;" "He would learn more about crime from older inmates;" "There's too many boys get together and each boy has different troubles and they discuss them so they think next time I wouldn't get caught;" "If you throw a partly good apple in with rotten apples, both get rotten;" "Reformatories are crime breeders."

The opponents of reform schools also say that the youngster sent there would feel unloved and unwanted and get a grudge against the world. The reform school atmosphere would make him resentful and tough.

The extent of the change in the direction of modern ideas on juvenile delinquency is graphically portrayed in the age breakdowns in Table 6, and of course it is apparent in the education breakdowns also (not shown for lack of space). The older a person the more apt he is to support the "old-fashioned whipping" and the reformatory sentence and the less likely to advocate boy's clubs or psychiatric guidance. The gap between the oldest and the youngest groups is quite marked. The less education a person has had the more likely he is to follow the pattern of the older

age group, except for one anomalous instance. The proportion among the college-educated group who chose the boy's club as the preferred treatment alternative is *less* than that among those with only a high school education. It may be that the college-educated recognize the boys' club as a preventive rather than treatment technique—when a boy actually becomes delinquent it may make more sense (they seem to be saying) to bring in a psychiatrist or a probation officer.

IV

There have been some hints in the foregoing paragraphs that the psychiatrist is beginning to gain popular recognition as a resource in dealing with personality problem cases. Actually how much recognition does he have today, and in what context does he fit in the public mind? Is he regarded as a medicine man with a mysterious magic for curing personality disorders? Is he viewed as a special type of doctor, and trusted as a doctor is trusted? Is he regarded as a poor sort of beginner scientist but the best thing available at present? Or do people think he is an overcharger and a near-quack?

The study supplies several bits of evidence that bear on these questions. First, there are the responses to the true-false statement question on whether it is "always worthwhile to get a psychiatrist's help when someone begins to act queerly or get strange ideas?" The results (Table 7) indicate that the irreconcilable opposition

TABLE 7

Question: "*It's always worth while to get a psychiatrist's help when someone begins to act queerly or get strange ideas. On the whole, do you think this statement is more true than false, or more false than true?*"

	Total Sample	Respondents Whose Formal Education Ended in		
		Eighth Grade or Less	High School	College
No. of Respondents	3971	1745	1589	533
Per Cent Distribution of Replies				
True	81	83	81	79
False	10	10	10	10
Don't know and No answer	9	7	9	11

to the psychiatrist is now relatively small—8 out of 10 Louisvillians think that the psychiatrist's help is worth having when the person is pretty clearly a mental problem case, and education does not affect this ratio. Of course the question is, in a sense, loaded a little in favor of the psychiatrist since a person *could* reason: "Psychiatrists probably can't help much but at least it won't do any harm to try them." But no one who is really antipsychiatrist will fall in this category.

When the 19% who do *not* believe the statement (in Table 7) is true were asked *why* they felt that way, it was found that the active opponents of psychiatry were very few indeed. Table 8 shows the results after coding and tabulating these "why" answers. The largest group of respondents were simply loath to take such a drastic step as to call in a psychiatrist until other resources had been first exhausted. One of their reasons for this hesitance was apparently a feeling that the mere fact of reference to a psy-

TABLE 8

Question: "*Why do you feel that it's not always worthwhile to get a psychiatrist's help when someone begins to act queerly?*" (Asked of those who answered "False" or "Don't know" to the question in Table 7)

No. of Respondents	Sub-totals	Total
		683
	Per Cent	
	Distribution of Replies	
Should try other help first	.	34
Family doctor is better, should be consulted first	10	..
Minister or priest is better, should be consulted first	3	..
Family or friends are better, can help more	3	..
People should try to work it out themselves	3	..
Other (try other help)	2	..
Psychiatric help not necessary in many instances (some cases not serious enough: everyone is a little queer, etc.)	..	15
Make person worse to see a psychiatrist: create sus- picion he is mentally ill	..	6
Don't believe in psychiatrists—don't have faith in them	..	5
Should only go to a psychiatrist if he was first-rate— many are not	..	4
Some people are afraid of psychiatrists	..	2
All other	..	6
Don't know and No answer	..	46

chiatrist would frighten the patient into thinking he was very ill. Doubts as to the competence and/or honesty of psychiatrists were expressed rarely and the people who would oppose calling in any psychiatrist because of expressed lack of faith in them as a group appear to be less than 1% of the total population.

A second kind of appraisal of the psychiatrist's position in public confidence is provided through the question responses shown in Table 9. Two issues, at least, are involved in choosing types of

TABLE 9

Question: "If a city or state government decided to spend a lot of money to help prevent mental illness, which four of the kinds of people on this list would you like to see on the committee that was to decide how to spend the money?" (Card shown respondent)

	Per Cent Distribution of Replies							
	Respondents Whose Formal Education Ended in				Respondents Whose Ages Are			
	8th				65			
	Total Sample	Grade or Less	High School	Col- lege	18-24	25-44	45-64	and Over
A priest or minister or rabbi	62	60	67	58	63	62	63	57
A family doctor	60	66	59	53	55	59	64	65
A psychiatrist	42	29	52	63	53	48	36	21
A social worker	39	37	41	45	44	40	37	33
A mother	35	42	34	22	34	32	40	41
A juvenile court judge	33	36	32	34	31	33	34	34
A mental hygienist	24	18	30	30	34	27	19	15
A businessman	21	20	22	24	16	22	22	19
A school principal	16	21	12	11	15	15	17	18
A banker	11	12	10	10	8	11	12	12
A psychologist	8	5	10	15	11	10	5	4
A psychoanalyst	8	5	10	13	10	10	6	3
A sociologist	5	2	5	15	7	6	3	3
Don't know and No answer	7	9	3	2	4	5	8	16

people to supervise a publicly financed program for mental health. First, there is the question of whether the program should be put in charge of "experts" or in the hands of respected but non-expert individuals. Second, there are the related questions of who is an expert in the public's mind and whom among the experts does the public trust?

Table 9 indicates that in general an "expert" committee is favored, and the more education the respondent has had the more he wants to see the mental health program run by professionals. It is true that the "priest, minister, or rabbi" heads the list of preferred committee members in the Louisville population as a whole, and is number two even among the college-educated, but it is clear from the study as a whole that this individual qualifies as an expert in the minds of many, and as a mental hygienist and counselor for the non-psychotic he is indeed often entitled to that status. Numbers two, three, and four on the list are the family doctor, the psychiatrist, and the social worker, and all of these fall in the expert category. Far down on the list come the businessman and the banker. There is a theory in our culture that the businessman is the one to be trusted if public money is to be spent effectively and efficiently on any project, but this theory seems to be rejected in this instance.

Within the roster of experts the psychiatrist's stock is clearly on the rise. Note how his support increases with decreasing age and increasing education. The social worker, the mental hygienist, and the psychologist all show the same pattern of increased prestige among the young and the educated, although with less total support than is given the psychiatrist. The family doctor pattern is the reverse, he loses support where these other experts gain it, but he still remains high on the list of choices for all sub-groups. As for the sociologist, the kindest thing to say is that he is a "pure scientist" and doesn't belong on the committee anyway. But it is to be doubted that this was the reason why so many left him off their list!

There is a third bit of so-far-unreported evidence concerning the public's view of psychiatry and psychiatrists. People were asked whether the following statement was more true than false or more false than true: "The experts themselves often can't agree on whether a man is mentally ill enough to be put in an insane asylum or not." The statement is possibly loaded somewhat in favor of a "true" response (except for the word "often"), since many people have no doubt read of the disagreements between state and defense alienists in the big criminal trials. Nevertheless, 27% of the total sample and 31% of the college-educated declared the statement "false." Another 23% of Louisvillians would express no opinion as to its truth or falsity.

It is not easy to summarize in a sentence or two the conclusions on the position of the psychiatrist that one may safely draw from

the results presented in this and the preceding sections. The psychiatrist is a relative late-comer in the ranks of guidance experts, and attitudes toward him are still undergoing fairly rapid changes. As a resource in dealing with clear-cut cases of "insanity" or extreme and obvious mental disorder, his status seems already to be well established. It is in connection with the borderline instances of "people in trouble" and "people who are a bit queer or neurotic" that his role is still undefined. It seems clear that Louisville citizens know much better when to call in a doctor to treat a serious physical illness than they do when to call a psychiatrist to deal with a serious mental illness. In the first place, the extent of the physical illness is easier to recognize; in the second place, the very fact of mental illness involves a stigma which makes people resist facing the fact of psychosis. Calling in the minister, the family doctor, or the best friend involves much less loss of face for the individual and his family than if a psychiatrist is consulted. It would seem to be one of the psychiatrist's major problems today to break down the "nut doctor" and the "last resort" associations in the public mind and qualify as a counselor, a mental hygienist, and a person who deals with the less serious personality problems, as well as with the candidates for mental hospitals, shock treatments, and the other drastic treatments that have been publicized in the magazines and the films.

V

We have already seen that the college-educated group is well ahead of the rest of the population in its adoption of modern attitudes on mental health. This was to be expected. It was equally to be expected that the professional groups in the society would also be "progressive" in viewpoint, partly because of formal education, partly because of contacts and experience. But which professional groups are most up-to-date in their viewpoints? Since the members of professions are likely to be influential in the community it is important to know which groups provide what sort of leadership on mental health.

In the Louisville study lawyers, doctors, school teachers, and members of the clergy were "oversampled" by selecting names systematically at random from lists of all such people in the city, and the extra interviews made with these people were added to the interviews which came about naturally in completing the population cross-section. While the total number of interviews in

each professional group was still relatively small (100-135) a good many of the comparisons made between the groups involved such large differences as to be statistically reliable. Table 10 summarizes some of these comparisons.

TABLE 10. COMPARISONS BETWEEN RESPONSES
OF DOCTORS, LAWYERS, TEACHERS, AND
CLERGYMEN ON SOME QUESTIONS IN
THE MENTAL HEALTH STUDY

	Total Sample	Law- yers	Doc- tors	Teach- ers	Clergy- men
No. of Respondents	3971	108	123	135	116
Per cent of respondents who favor:					
Sending the juvenile delinquent (Table 6) to a psychiatrist	25	27	49	54	33
Putting him on juvenile probation	7	18	5	1	6
Sending Mrs. B (Table 4) to a mental hospital	7	8	29	..	6
Calling in the minister or priest	26	13	17	..	50
Sending Mr. G (Table 5) to a psychiatrist	11	..	43	..	25
Per cent of respondents who believe that:					
Most mental illness is inherited (Table 1)	17	16	19	4	13
Most hospitals for the mentally ill treat patients very badly	22	31	18	19	22
The experts often can't agree on whether a man is mentally ill enough to be put in an insane asylum	50	76	50	53	63
It's always worthwhile to get a psychiatrist's help when some- one begins to act queerly or get strange ideas	81	58	89	75	72
On the committee to spend public money to help prevent mental illness (Table 9) there should be a:					
Psychiatrist	42	60	80	70	54
Juvenile court judge	33	36	40	23	39
Businessman	21	68	51	22	19
School principal	16	8	15	10	7
If a member of the family became mentally ill they would <i>not</i> tell friends or acquaintances about it	47	68	47	50	46

The only clear-cut, over-all generalization that emerges after an examination of the Table is that the lawyers are the most conservative and, from the mental hygienist's point of view, the least enlightened group. Lawyers are more likely to resort to repressive measures in dealing with juvenile delinquency and mental illness (there was not enough space to include all the evidence on this point), they show considerably less faith in psychiatry than the other professional groups, and they are not much better informed on local facilities for care of mental patients than the population as a whole (again the evidence is omitted⁶). Since the lawyers as a group occupy a position of great power in our governmental structure, their opinions about psychiatry and the need for treatment facilities are of considerable importance. Neither their education nor their present contacts seem to be functioning adequately to keep them up-to-date on current trends.

The other groups (teachers, doctors, clergymen) do not differ so much among themselves as they all differ from the lawyers. The doctors not surprisingly show a stronger faith in psychiatry, and the clergymen in religion, than do the other groups. The teachers are most willing of all groups to see the juvenile delinquent have psychiatric treatment, and in general their position is somewhat closer to that of the sociologist or social worker than is that of the clergyman or doctor. The teachers do not show any special eagerness to have a school principal on the committee administering mental health funds—apparently they think that even a businessman would do a better job!

VI

This paper can report only a small part of the evidence from the Louisville study but it may be said that in general the findings on the unreported questions support the conclusions arrived at in the preceding pages. These conclusions may be recapitulated as follows:

1. The public has come a considerable distance in giving up old beliefs and superstitions about mental illness and in adopting more modern, scientific viewpoints.
2. There is still a gross failure to recognize serious mental

⁶ It is planned to publish separately some results of questioning on knowledge about local facilities for the care of mental patients and attitudes toward the quality of treatment given.

symptoms, at least when they are described in words. The story may, of course, be different when the people themselves are under observation.

3. There is considerable loss of faith in repressive and punitive techniques, especially in dealing with juveniles.

4. There seems to be no strong negative reaction to the psychiatrist and he is coming to be regarded as the logical person to handle clearly identifiable cases of mental disorder. He is also beginning to be regarded as a useful resource in dealing with less serious personality problems, although here he is still handicapped because of a certain stigma that attaches to his subjects.

5. The lawyers represent a minor stronghold of reaction against psychiatry and against modern ideas of how to treat juvenile delinquency.

Patients of a State Mental Hospital: The Outcome of Their Hospitalization*

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TODAY about 100,000 Americans are admitted annually to state mental hospitals; considerably more than half that number are released each year.¹ What happens to these patients after they return to their families, communities, and jobs is a question of sociological import. The success of their readjustment in these social situations is perhaps not a psychiatric definition of recovery. However, the extent to which they are accepted again in community life is an indication of the recovery level attributed to them by their associates. This measure of their recovery is the socially effective one. As W. I. Thomas said, "If men define situations as real, they are real in their consequences."

Outcome of hospitalization for mental illness was the major concern of a recent study of patients at Arkansas' state mental hospital.² The sample was composed of patients admitted from two Arkansas counties between 1930 and 1948. Included were 502 patients from Washington County and 552 patients—a 50 per cent, statistically random sample—from Jefferson County.³

* Prepared especially for this volume.

¹ Federal Security Agency, *Patients in Mental Institutions 1949* (Washington, D. C.: U.S. Government Printing Office, 1952), p. 15.

² The study was sponsored jointly by the Arkansas State Board of Health, the Arkansas State Hospital, and the Institute of Science and Technology, University of Arkansas, the latter agency actually carrying out the investigation. A part of the financial support was provided by the above named agencies, and a part was provided by a research grant, M-499, from the National Institute of Mental Health of the National Institutes of Health, Public Health Service.

³ A monograph summarizing the Washington County study has been published. Leta M. Adler, James W. Coddington, and Donald D. Stewart, *Mental Illness in Washington County, Arkansas: Incidence, Recovery, and Posthospital Adjustment* (Little Rock and Fayetteville, Arkansas: Arkansas State

The populations of both counties were more than 50 per cent rural. Washington County is partly in the Ozark mountain area, partly in a plains area. It is characterized by: diversified farming; single-family farms; an almost completely white, native-born population; and no city of more than 20,000. Jefferson County is in the Mississippi delta; its rural economy is characterized by cotton plantations; 55 per cent of its population is Negro; and it has one city of close to 40,000 population. Neither county possesses personnel or facilities for the care or treatment of mental patients within its bounds.

Hospital admission rates, based on 1940 population, were 6.96 per 10,000 for Washington County and 8.24 for Jefferson County. The comparable rates for Arkansas and the U.S. were 7.23 and 8.01, respectively. Admission rates were higher for men than women, and for older persons than younger persons, though admission rates dipped in the 15 years following the fortieth year of age. Rates were also higher for single, widowed, and divorced persons than for married persons. When marital status at onset of illness rather than at hospital admission was considered, the rate of admission was not greater among the single persons of Jefferson County than among married persons. This would seem to indicate that the higher rate for persons who were single at the time of hospitalization was the result of reduced opportunity for marriage after the onset of mental illness. Rates for widowed and divorced persons were high when considered at the time of onset.⁴

Proportionately more unskilled workers and fewer white-collar workers were found among the patients than among the comparable county populations. However, there were proportionately more Negro white-collar workers among the patients than among the total Negro population of Jefferson County. A larger proportion of the patients were without formal schooling than were the general populations of the two counties. In Jefferson County, the admission rate for whites was slightly higher than for Negroes, but the rates for both Negro males and females were higher than for white females. Differences in admission rates found among various segments of the population do not necessarily represent

Hospital, Arkansas State Board of Health, and Institute of Science and Technology, University of Arkansas, 1952).

⁴Leta M. Adler, "The Relationship of Marital Status to Incidence of and Recovery from Mental Illness," *Social Forces* (Dec. 1953), pp. 185-194.

differences in their susceptibility to mental disorders. Some mentally disabled persons were treated elsewhere and others were not treated at all. Admissions to the State Hospital were also influenced by the varying efficiency of referral agencies, varying tolerance of mental peculiarities, admission policies of the hospital, and other factors not related to the number of persons actually suffering from mental disorders.

Mental disabilities of most types were represented among the patients studied: the psychoses, the psychoneuroses, the psychopathic personality, alcoholism, and mental deficiency. For all patients admitted to the State Hospital, schizophrenia, psychosis with arteriosclerosis, and senile psychoses were the three most frequent diagnoses, in that order of importance. These disorders were similarly ranked among Washington County patients. General paresis displaced senile psychosis as the third most important diagnosis among Jefferson County patients. There were significantly fewer non-psychotic alcoholics among Washington County patients than among total admissions.

Hospital records were the starting point of the study. They were searched for background data on each person in the sample, for information about the hospital stays of each patient, and for the addresses of persons who might be interviewed concerning the patients. Information about the adjustment of patients after release from the hospital was obtained by personal interview with close relatives or friends of former patients in all but a few instances. The interviewers were sociologists, psychologists, or social workers, especially trained in research interviewing techniques. Interviews were conducted in Washington County in 1949, and in Jefferson County in 1950.

Patients were first classified by their status at the time of the study into the broad categories of Table 1 by asking the questions: Is he still living; is he still hospitalized? The proportions of persons classified in each category of Table 1 were very similar for Washington and Jefferson County patients.

PATIENTS WHO DIED IN THE STATE HOSPITAL

The most immediately striking feature of Table 1 is the fact that close to one-half the patients had died since their first admission to the State Hospital and that most of these deaths occurred in the hospital. During an average length of stay of 27 months (in-

TABLE 1. STATUS AT THE TIME OF INTERVIEW OF
502 PATIENTS FROM WASHINGTON COUNTY,
1949, AND 552 PATIENTS FROM JEFFERSON
COUNTY, 1950, ADMITTED TO ARKANSAS
STATE HOSPITAL, 1930-1948

Status at Interview	Washington County		Jefferson County		Total	
	Num- ber	Percent- age	Num- ber	Percent- age	Num- ber	Percent- age
Living at home	156	31.1	170	30.8	326	30.9
Died after release	66	13.1	73	13.2	139	13.2
In another mental hospital	4	0.8	6	1.1	10	1.0
Unknown	31	6.2	40	7.2	71	6.7
Total released	257	51.2	289	52.3	546	51.8
In hospital on first admis- sion	34	6.8	13	2.4	47	4.5
In hospital on readmission	51	10.1	48	8.7	99	9.4
Total in State Hospital	85	16.9	61	11.1	146	13.9
Died in State Hospital	160	31.9	202	36.6	362	34.3
Total admitted	502	100.0	552	100.0	1054	100.0

cluding all admissions of each patient), 34 per cent of the patients died,⁵ compared to less than 3 per cent of the general population who would be expected to die in the same length of time.⁶ While the patients tended to be older than the general population, this fact did not account for the higher death rate. The hospital death rate was higher at every age than that of the general population.⁷

Among the 362 patients who died in the hospital, 309 died during first admission, and the remaining 53 died during readmissions. Forty per cent had been hospitalized less than 2 months at death and another 20 per cent died during the remainder of the first year of hospitalization. The large proportion of deaths during the

⁵ The death rate for Arkansas State Hospital was less than that for all state hospitals in 1949. Federal Security Agency, *Patients in Mental Institutions 1949* (Washington, D. C.: U. S. Government Printing Office, 1952), pp. 15, 25-28.

⁶ Greville, Thomas N. E., *United States Life Tables and Actuarial Tables 1939-1941* (Washington: U. S. Government Printing Office, 1946), pp. 2, 26-27.

⁷ See Adler, Coddington, Stewart, *op. cit.*, Table IV, p. 71, for Washington County hospital death rates by age-group. Comparable data for Jefferson County show the same trend but are unpublished.

early months of hospitalization suggests that many patients were in advanced stages of illness at the time of admission. This conclusion is supported by observing that 48 per cent of the Jefferson County patients who left the hospital during the first 2 weeks following admission did so by reason of death, and 53 per cent of Washington County releases during the first month were deaths.⁸

When deaths are regarded as a proportion of releases, it is clear that (after the first weeks) the longer a patient remained in the State Hospital, the greater was the probability of his dying there. Among both Washington and Jefferson County patients, deaths were close to 30 per cent of all releases during the first year of hospitalization, a little over 50 per cent of all releases after 1 to 5 years of hospitalization and about 65 per cent of all releases after 6 to 10 years. All patients who left the hospital after 10 years or more did so by reason of death.

Of the Negro patients, 50 per cent from Jefferson County died in the hospital, while 23 per cent of the white Jefferson County patients and 32 per cent of the Washington County patients died while hospitalized. These are much larger differences than exist between white and Negro death rates in the general population⁹. Of the male patients 36 per cent and of the female patients 31 per cent died in the hospital.

Among patients from both counties, those with organic psychoses associated with advanced age (senile psychoses and cerebral arteriosclerosis) had the highest death rates, followed by psychoses associated with syphilis. The patients with functional disorders—those without known physical basis—had the lowest death rates, except that, for both samples of patients, the catatonic schizophrenics had somewhat higher death rates than did those with other functional disorders.¹⁰ Patients whose mental illnesses were classified as "undiagnosed" also had exceptionally high death rates, presumably because in many instances they were admitted in such advanced states of illness that diagnosis was not possible before they died.

⁸ Washington County schedules were not processed to obtain information for the first two-week period.

⁹ Greville, *op. cit.*, p. 2. The hospital was operated on a segregated basis during the period in question.

¹⁰ See Adler, Coddington, Stewart, *op. cit.*, p. 29, Table 16, for Washington County data. Comparable Jefferson County data are unpublished.

Diseases of the circulatory system, principally heart disease, which accounted for 27 per cent of patient deaths, were the most important cause of death among patients, as well as among the general population of the state. Cerebral hemorrhage, pneumonia, and syphilis were the next most frequent causes of death and were about equally important among the total group of patients, together accounting for more than one-third of all patient deaths. The latter two were considerably more important among the patients than among the general population.¹¹

PATIENTS WHO DIED AFTER RELEASE

Before arriving at the patients of greatest interest to the study, those who were released from the hospital and living at home in their communities, it is necessary to consider another group, the 139 patients who had been released from the hospital and had since died. These patients represented 13 per cent of the total among both the Washington and Jefferson County admissions. (Table 1). This death rate was almost twice as high as that which would be expected in the general population in a comparable length of time.

Accidents, poisoning, and violence constituted the most frequent cause of death among released patients; almost 1 in 4 deaths among those for which cause was known was due to this group of causes. Suicide accounted for 12 deaths, all among white former patients. Such causes of death were rare among hospital deaths, accounting for only 4 among 362 deaths. This would seem to indicate that the hospital was more adequate in carrying out its custodial function than were the patients' families. The next most important cause of death was diseases of the nervous system, followed by diseases of the circulatory system.

Three other groups of patients should be mentioned in passing; these are the 146 patients (14 per cent) in the State Hospital at the time of the field investigation, the 10 patients (1 per cent)

¹¹ Carl W. Backman and Donald D. Stewart, *Mortality and Mental Illness in Two Arkansas Counties*, Arkansas State Hospital and Arkansas State Board of Health, Little Rock, and University of Arkansas, Institute of Science and Technology, Fayetteville, November 1952 (mimeographed), Appendix pp. 1, 3-5 for detailed information on causes of death for Washington and Jefferson County patients combined into one group. See also Adler, Coddington, and Stewart, *op. cit.*, p. 73 for the same information on Washington County patients considered separately.

in some other mental hospital at that time, and the 71 patients (7 per cent) about whom nothing was known after their release. This latter group did not vary significantly from the total admissions by race or sex, but a larger proportion were released in the earlier years of the period investigated. Since the only method of securing names of informants was the hospital record made before or at release, finding the current addresses of informants for earlier releases was more difficult.

PATIENTS AT HOME

The 326 patients who were at home at the time of the investigation were not typical of the total group of admissions in some ways. Examination of groups previously discussed would lead one to expect this. In the first place, patients in this group tended to be younger at admission than the total group. Only 9 per cent of the released group were 60 years of age at the time of admission while 25 per cent of all persons admitted had reached this age by the time they were admitted. Most persons of advanced age at time of admission had died before 1949 or 1950. On the other hand, persons at home tended to be a little older than persons in the hospital at the time of the study. This was probably because persons who left the hospital were more likely to survive than patients who remained in the hospital. Age at first admission is the clue for explaining the observed differences between the patients at home and other admissions with regard to diagnosis. There were conspicuously fewer persons with diagnoses associated with old age—cerebral arteriosclerosis and the senile psychoses. On the other hand, patients at home included a larger proportion who were diagnosed as having involutional melancholia, psychoneurosis, manic-depressive psychosis, schizophrenia, or alcoholism (without psychosis).

The patients at home included 186 males and 140 females. The proportion of males in this group (57 per cent) was very nearly the same as among all admissions (61 per cent), the higher death rate of the males being canceled out by the higher proportion of women among patients still hospitalized. Among the Jefferson County patients, 99 white and 71 Negro persons were at home. Only 42 per cent of this group were Negroes as compared to 52 per cent of the total admissions, this difference being the result of higher Negro hospital mortality.

Investigation of the patients who were living at home at the time of the follow-up study centered around three broad areas: adjustment to the economic world, participation in the social activities of the community, and adjustment in marriage and family life. It was not possible to obtain all the required information on all former patients known to be living at home. Some patients had moved out of the area, and informants still residing in the area were unable to give detailed information concerning them.

Occupational Adjustment. Fundamental to adequate social adjustment is the ability to carry on a life task. For most adult men this means engaging in a gainful occupation; for women it may mean either homemaking or employment outside the home. In Table 2, the employment status of the released patients for whom this information was obtained is compared with employment status among the general populations of the two counties. The proportion of former patients reported to be "doing nothing" is greater in both counties than the comparable group in the general population ("Other not employed" in Table 2). More than 25 per cent of the former patients in each county were in this category as compared to 7 per cent of the general population in Washington County and 14 per cent in Jefferson County. Presumably these figures indicate a substantially higher proportion of unemployability among the former patients than in the general population.

On the other hand, the proportion of persons who were gainfully occupied was very similar for former patients and comparable county populations. While all the former patients not gainfully occupied were either keeping house or unemployed, a substantial proportion of persons over 14 years of age in the total population were in school. There were no students among the patients. This difference is largely accounted for by the fact that the patients tended to be older than the total population, no former patients being under 19 years of age. In other words, the proportion of former patients gainfully occupied would be less than the proportion of the general population gainfully occupied if they were compared with persons above school age in the general population.

The proportion of self-employed among employed former patients varied very little from that found in the county populations. However, in Washington County especially, there was a

TABLE 2. EMPLOYMENT STATUS OF 136 WASHINGTON COUNTY PATIENTS AND 160 JEFFERSON COUNTY PATIENTS IN 1949 AND 1950, RESPECTIVELY, COMPARED WITH THE GENERAL POPULATIONS OF THE COUNTIES, 14 YEARS OF AGE OR OVER, 1950*

Employment Status	Washington County			Jefferson County		
	Patients		Pop- ulation Percent- age	Patients		Pop- ulation Percent- age
	Num- ber	Percent- age		Num- ber	Percent- age	
Farm operators	10	7	10	13	8	8
Other self-employed	7	5	5	10	6	4
Total self-employed	17	12	15	23	14	12
Farm workers †	18	13	5	7	5	3
Other employees †	28	21	27	48	30	29
Total employees	46	34	32	55	35	32
Keeping house	38	28	28	37	23	30
Students ‡	—	—	18 §	—	—	12 §
Other not employed	35	26	7	45	28	14
Total not gainfully employed	73	54	53	82	51	56
Total population, 14 years or over	136	100	100	160	100	100

* U. S. Bureau of the Census. *U. S. Census of Population: 1950*. Vol. II, *Characteristics of the Population*, Part 4, Arkansas, Chapter B (Washington, D. C.: U. S. Government Printing Office, 1952), pp. 79, 82, 87, 92.

† Including unpaid family workers.

‡ Based on 20 per cent census sample. Probably represents an overestimate, since persons enrolled in school part-time are included. The University of Arkansas in Washington County is responsible for the larger proportion of students in that county.

§ Estimated.

higher proportion of farm workers among the former patients than among the general population.

A scale ranking the former patients according to occupational adjustment as indicated by work regularity was constructed. (Table 3)¹² This scale was based on the theory that persons who

¹² It was intended to include other items relating to occupational adjustment, such as job fatigue and relations with co-workers. However, informants' reports on these questions were almost uniformly favorable. Employers might have given more adequate information on these aspects of occupational adjustment, but it was decided not to interview them in order to protect the former patients from possible discrimination.

TABLE 3. WORK REGULARITY OF 291 FORMER WASHINGTON AND JEFFERSON COUNTY PATIENTS CLASSIFIED BY SCALE SCORES AND SCALE TYPES, 1949 AND 1950

Scale Score	Description of Scale Type	Patients		Total Patients	
		Male	Female	Number	Per Cent
1	Worked regularly since release; gainfully occupied at interview.	55	21	76	26
2	Worked some of the time since release, and more than half the time in last six months; gainfully occupied at interview.	18	8	26	9
3	Worked some of the time since release; worked in last six months, but less than half the time; gainfully occupied at interview.	22	9	31	10
4	Worked some of the time since release; worked in last six months, but less than half the time; not gainfully occupied at interview.	14	14	28	10
5	Had worked some since release, but not gainfully occupied at interview.	23	17	40	14
6	Not gainfully occupied since release.	29	61	90	31
Total		161	130	291	100

scored well on the item on which the fewest persons scored well should also score well on all other items. For example, in the Work Regularity Scale, those former patients who had worked regularly since their release had also worked regularly in the six months prior to interview and were gainfully occupied at the time of interview. Each scale type represents a shift to a less-favorable rating on one scale item, the least-favorable scale type including an unfavorable rating on every scale item.¹⁸

¹⁸ Adler, Coddington, Stewart, *op. cit.*, contains a non-technical discussion of Guttman Scales. See Appendix A, pp. 61-65.

The method of constructing the Guttman Scales employed in this study is described in a mimeographed reprint of "The Cornell Technique Scale and Intensity Analysis," a paper presented by Louis Guttman to the Conference on Measurement of Consumer Interest which was held at the University of Pennsylvania in May, 1946. For a more detailed and technical discussion of the Guttman Scale technique, see Stouffer, Samuel A., Louis Guttman, et al., "Measurement and Prediction," *Studies in Social Psychology in World War II* (Princeton, N.J.: Princeton University Press, 1949), Vol. 4. Includes a bibliography of other sources on this scaling technique.

The two most frequent Work Regularity Scale scores were 1, which indicated regular employment since hospital release, and 6 which indicated no gainful employment since release. This was true for both men and women. Of the men, 34 per cent had worked regularly since release; 18 per cent had not worked at all since release; and the remaining 48 per cent had worked with varying degrees of regularity since release. Of the women, 16 per cent had worked regularly, 47 per cent had not been gainfully occupied at all, and the remaining 37 per cent had been employed with varying degrees of regularity. For males this probably represents less regular employment histories than one would expect in a general population. It is not so clear that this is the case for women. Married males among the group of released patients had worked more regularly than unmarried males.

The occupational adjustment of former patients as a whole was no better, and sometimes less adequate at the time of interview than in the period just prior to hospitalization. During this time, mental illness had already affected occupational adjustment. Thus it may be presumed that for the group occupational adjustment level was lower at the time of the interview than it was before the onset of mental illness. In Washington County, the proportion of persons in each occupational group and in each employment status prior to hospitalization as well as their work regularity in the six months prior to hospitalization did not vary significantly from what was found at the time of the field investigation. In Jefferson County, the same comparison with regard to employment status showed a larger proportion gainfully occupied just prior to hospitalization than at time of interview. Only 9 per cent at time of hospitalization as compared with 28 per cent at interview were reported not to be doing anything. When occupations were ranked by skill according to an adaptation of Warner's classification,¹⁴ it was found in Jefferson County that 17 per cent had improved their skill level, 51 per cent had maintained their skill level, but 32 per cent were engaged in an occupation of lower skill level. With regard to work regularity, the comparison for Jefferson County patients was between the 6 months prior to onset of illness and the 6 months just prior to interview. This gave a direct comparison with "normal" work regularity. It was found that in the period before interview, 24 per cent of the patients for whom the comparison could be made worked

¹⁴ W. Lloyd Warner, Marcia Meeker, Kenneth Eells, *Social Class in America* (Chicago: Science Research Associates, Inc., 1949), pp. 134, 140-141.

more regularly than in the period before onset; 32 per cent had worked about as regularly; and 44 per cent worked less regularly.

Social Participation. The participation of former patients in the formally organized and the informal social life of their communities was also considered as an aspect of their readjustment. Social participation reflects ability to conform to expected patterns of behavior, acceptability as an associate, and, to some degree, contribution to the community.

A Social Participation Scale (Table 4) indicated that more released patients participated in the informal social activity of home

TABLE 4. SOCIAL PARTICIPATION OF 269 FORMER WASHINGTON AND JEFFERSON COUNTY PATIENTS CLASSIFIED BY SCALE SCORES AND SCALE TYPES, 1949 AND 1950

Scale Scores	Description of Scale Types	Patients	
		Number	Percentage
1	Belonged to at least one organization; attended four or more meetings in month prior to interview; visited and was visited at least twice in month prior to interview; visited at least as often as rest of family	63	23
2	Belonged to at least one organization; attended one to three meetings in month prior to interview; visited and was visited at least once in month prior to interview; visited at least as often as rest of family	83	31
3	No participation in organizations; visited and was visited at least once in month prior to interview and at least as often as rest of family	34	13
4	No participation in organizations; visited and was visited at least once in month prior to interview but less than rest of family	13	5
5	No participation in organizations; visited or was visited less than once a month and less than rest of family	25	9
6 (Non-scale)	No participation in organizations; visited and was visited less than once a month but as often as rest of family	16	6
7	No participation in organizations; visited and was visited less than once a month and less than rest of family	35	13
Total		269	100

visiting than participated in organized groups. This was found to be true also of other types of informal social activities included in the Jefferson County but not the Washington County study and therefore not included in the present scale.¹⁵

About one-half the group of former patients participated in organized groups (Scale Types 1 and 2), and these persons also participated in informal types of social activity. The proportion of released patients participating in organized groups was no smaller than the proportion found in most studies of general populations.¹⁶

Two-thirds of the former patients classified on the scale made and received home visits at least once a month and at least as often as the other members of their families (Scale Types 1-3). The visiting behavior of other family members is as good an indication as is available of the amount of this kind of socializing expected of persons in the particular social settings of the patients. Another small group of patients (Non-Scale Type 6) visited as often as their families, but the family carried on little or no home visiting. The remaining 27 per cent did not belong to any organization and visited less than their families (Scale Types 4, 5, 7). Those classified in Scale Type 7, 13 per cent of the total, had little or no social participation. The more extensive interviews of Jefferson County patients revealed that those in this group seldom or never went to town, never participated in social activities of their own accord, and about one-half always went out alone if they did go out.

Differences between men and women and between whites and Negroes were not great with regard to social-participation scale scores. Married persons of both sexes and both races scored higher than the group of single, widowed, divorced, and separated persons. About four-fifths of the married persons were classified in Scale Types 1-3, while less than three-fifths of the not-married

¹⁵ Except for a few cases classified in non-scale types, ranking of a person from Jefferson County remained the same when classified according to the Washington County Scale used here.

¹⁶ Such studies would include Charlton, J. L., *Social Aspects of Farm Ownership and Tenancy in the Arkansas Ozarks* (Fayetteville, Arkansas: Agricultural Experiment Station, University of Arkansas College of Agriculture, 1947), pages 40-41; Kolb, J. H. and E. de S. Brunner, *A Study of Rural Society* (New York: Houghton Mifflin, 1940); Bushee, F. A., "Social Organization in a Small City," *American Journal of Sociology*, Vol. 51 (November, 1945), pp. 217-226.

were classified in these scale types. Only 7 per cent of the married persons but 21 per cent of the not-married group were classified in Scale Types 6 and 7 indicating little or no social participation.

Marriage and Family Adjustment. The marriage and family adjustment of the former patients was considered from the standpoint of their ability to marry and remain married, and of the quality of their participation in family life.

Of the former patients from Washington and Jefferson counties, 48 per cent were married at the time of interview in comparison with almost two-thirds of the population of Arkansas 20 years of age or over.¹⁷ Since 21 per cent of the former patients had never married, as compared to 14 per cent of the general population, their ability to do so appears to be somewhat limited even after hospital treatment. It has already been pointed out that mental illness prior to hospitalization had reduced this group's opportunity for marriage, and for those with long illnesses, age entered into their ability to marry after release. The former patients also showed less ability to remain married, 20 per cent of them as compared to 5 per cent of the state's population being divorced or separated. The proportion of widowed persons was almost the same for the patients as for the general population.

In each of the two county studies the quality of marriage and family relationships was measured by scales. However, the items selected for these in the investigations of the two counties were so different that a combined scale could not be constructed. Several items from the area of marriage and family adjustment were included in the Total Adjustment Scale discussed below (Table 5). That scale indicates that more than two-thirds of the former patients were reported to be getting along well with their families.

Over-all Adjustment and Recovery. The three separate areas of adjustment—occupation, social participation, and family life—were combined into one measure of adjustment. (See Table 5.)¹⁸ This Total Adjustment Scale indicates that 30 per cent of

¹⁷ Bureau of the Census, *Sixteenth Census of the United States, 1940*, "Population." Vol. IV, Characteristics by Age, Part 2 (Washington, D. C., U. S. Government Printing Office, 1943), pp. 122, 128.

¹⁸ The scale presented here consists of items which were comparable in scales from both counties. It does not change the rank ordering of any patients except a group of unmarried males included in Non-Scale Type 6.

the former patients were maintaining a level of adjustment which might be considered adequate or even superior in the general population (Scale Type 1). Men in this group were regularly employed; women who were not regularly employed were doing all their own housework. All were members of and attended at least one organization, made and received at least one home visit a month, and visited as often as their families. They were getting along well with their families and required no special consideration or care from family members. Released Washington County patients in this group were rated by interviewers as having "better than average" or "average" personality adjustment. No symptoms of mental illness were reported for released Jefferson County patients so classified.

An almost equal proportion of the patients were classified in Scale Types 2 and 3. They had not been regularly employed and not all the women in the group did their own housework. None participated in an organization. Otherwise this group was classified on the Total Adjustment Scale like those in the best-adjusted group. However, they were limited in their adjustment on items included in either the Washington or Jefferson County scales but not in the combined scale. This group was not homogeneous with regard to reported personality adjustment. In general, however, it was not so satisfactory as for the best-adjusted group. Some of this group probably fall within the "normal" range.

Persons in Scale Types 4 and 5, 23 per cent of the total classifiable, were more limited in their social adjustment and their personality adjustment was also impaired. Those in Scale Types 6-8 (18 per cent of those classifiable) required special consideration or even personal care from their families because of their mental condition. Persons in these scale types were quite limited in other aspects of adjustment as well (except Non-Scale Type 5, in some respects).

Women had somewhat better Total Adjustment Scale Scores than did men. The proportion of men and women classified in Scale Type 1, the most favorable score, was almost equal. However, 35 per cent of the women as compared to 23 per cent of the men were classified in Scale Types 2 and 3. At the other end of

The scale fitted unmarried males least well. They were frequently able to hold jobs and participate in social activities when they did not get along well with their family and were reported to require special consideration from family members; in others the opposite was true.

TABLE 5. TOTAL ADJUSTMENT OF 293 FORMER WASHINGTON AND JEFFERSON COUNTY PATIENTS CLASSIFIED BY SCALE SCORES AND SCALE TYPES, 1949 AND 1950

Scale Scores	Description of Scale Types	Patients	
		Number	Percentage
1	Regularly employed, or (if woman) did all own housework; belonged to and attended at least one organization; visited and was visited at least once a month and as often as rest of family; was getting along well with family; received no special consideration or care from family.	89	30
2	Irregularly employed or not employed since release and (if woman) did not do all own housework; otherwise like Type 1.	66	23
3	Irregularly employed or not employed since release; did not participate in organized groups; otherwise like Type 1.	18	6
4	Irregularly employed or not employed since release; did not participate in organized groups; visited and was visited less than once a month and/or visited less than rest of family; otherwise like Type 1.	34	12
5	Irregularly employed or not employed since release; did not participate in organized groups; visited and was visited less than once a month and/or less than the rest of the family; did not get along well with family; otherwise like Type 1.	32	11
6 (Non-scale)	Irregularly employed or not employed since release; belonged to and attended at least one organization; visited and was visited at least once a month and as often as the rest of the family; some did not get along well with family; received special consideration from family	15	5
7	Irregularly employed or not employed since release; did not participate in organized groups; visited and was visited less than once a month and/or less than rest of family; did not get along well with family; received special consideration or supervision from family.	22	7
8	Required help with eating, dressing, or cleanliness; otherwise like Type 7.	17	6
Total		293	100

the scale only 8 per cent of the women but 17 per cent of the men received scale scores 7 and 8. There was not a statistically significant difference between whites and Negroes among the former patients from Jefferson County although there was a somewhat larger proportion of whites than Negroes in Scale Type 1.

The difference in scale scores between married persons on the one hand and the group of single, widowed, divorced, and separated persons on the other was the most striking. Almost one-half (48 per cent) of the married persons but only 14 per cent of the not-married group received Scale Score 1. Thirty-four per cent of the former but 23 per cent of the latter were classified in Scale Types 2 and 3. Thus more than four-fifths of the married persons but less than two-fifths of the not-married group received the three most favorable scale scores. Only 11 per cent of the married but 33 per cent of the not-married group received Scale Scores 4 and 5. Non-Scale Type 6, composed entirely of the not-married group and almost entirely of males, included 10 per cent of the not-married group. Persons classified here had high social-participation scores, but were otherwise inadequate in adjustment as measured by the scale. Only 7 per cent of the married persons were classified in the two least-favorable Scale Types (7, 8) as compared to 20 per cent of the not-married.

Just as important as the adjustment of the former patients at the time of interview was a comparison of their adjustment at that time with their adjustment prior to the onset of mental illness. This comparison was termed *recovery level*. This definition is not necessarily the equivalent of the term *recovery* as employed in psychiatry.¹⁰

Considering both recovery and adjustment levels, the former patients were classified into the following outcome categories:

(1) *Those who had recovered and who had a satisfactory or superior adjustment.* These patients were at least as well-adjusted at the time of interview as they had been before the onset of mental illness. They were all classified in Scale Type 1 of the Total

¹⁰ The measure of recovery employed in Washington County was considerably modified for the Jefferson County study, and it was not possible to select a group of items common to both scales to construct a combined scale as was done for most other areas of investigation. Therefore, in combining the two samples only general categories derived from the scales were employed.

Adjustment Scale (Table 5). Of former patients 73, or 26 per cent of the 279 classifiable with regard both to recovery and adjustment, were in this category.

(2) *Those who had improved or recovered to a less adequate level than those above.* Former patients who had improved but not reached their pre-illness level of adjustment and those who were said to have recovered but whose level of adjustment was not so high as in the group above are classified here. This group included 141 former patients or 51 per cent of those classifiable.

(3) *No substantial improvement.* Patients who still had symptoms of mental illness and who were less adequately adjusted in practically all items of social adjustment than before their mental illnesses. There were 48 patients, or 17 per cent of the total classifiable, in this category.

(4) *Required personal care.* There were 17 patients, 6 per cent of the total, who required help from family members with regard to eating, dressing, or cleanliness because of mental disorder. They were correspondingly inadequate in other areas of adjustment considered and had made little or no recovery.

The proportions of patients classified in these four outcome categories were not significantly different for Washington and Jefferson Counties. Neither did males and females differ in outcome on the basis of the above classification. Males and females did not differ significantly by recovery level.²⁰ While there was a significant difference by sex in total Adjustment Scale scores, this difference was obscured by the grouping of scale scores adopted for the outcome categories.

While 35 per cent of the former white patients from Jefferson County were classified in the most favorable outcome category as compared to 22 per cent of the former Negro patients, this difference was not quite statistically significant (at the 5 per cent level). Furthermore, almost the same proportion of whites and Negroes were classified in each of the two least-favorable outcome categories. The fact that more Negroes than whites were classified in the group which had improved or recovered but not reached the level described for the best-adjusted groups—if it is not a chance difference—may result from cultural differences between

²⁰ While more men than women appeared in the scale types indicating least recovery among released patients from Washington County, this was not true for Jefferson County, and the difference was not statistically significant for the entire sample.

the two races in the given setting rather than in differences related to their mental illness.

Persons who were married and living with husband or wife at the time of interview had more favorable outcomes than did the group of persons who were single, widowed, divorced, or separated. Only 11 per cent of the former as compared to 34 per cent of the latter were classified in the two least-successful outcome groups. A special study of Jefferson County patients is of interest in this connection.²¹ It was found that most of the persons who were married at release remained married and had favorable recoveries at the time of interview. Many persons who were single at release and had favorable recovery levels at interview had married between release and interview. To a lesser extent this was true of persons who were divorced or widowed at release. These shifts in marital status of the not-married group could mean either that those who were making a good recovery married or remarried or that those who married or remarried found in marriage a favorable environment for recovery.

For Washington County released patients, some investigation was made into the ways in which some factors not discussed above were related to outcome of hospital treatment for mental illness. The outcome categories described above were employed for this purpose.

Favorable outcome was perhaps most strikingly related to the promptness with which the individual received treatment. Among persons who were admitted to the hospital within a year after the onset of illness, 29 per cent were classified as recovered to at least an adequate level, while only 10 per cent were reported to have made no substantial improvement or to require personal care (the two least-favorable outcome categories). Among those who waited more than a year before admission, 12 per cent were in the most-favorable outcome categories and 41 per cent were in the two least-favorable outcome categories.

The longer a patient had been released from the hospital the more likely he was to have made a favorable recovery by the time of the investigation. Of the patients released for the first time between 1930 and 1939, 36 per cent were classified in the most-favorable outcome category and 14 per cent in the two least-favorable outcome categories. Of those released after 1939, there were 13 per cent classified in the most-favorable outcome category

²¹ Adler, *op. cit.*, pp. 192-3.

and 28 per cent in the two least-favorable outcome categories. Only 9 per cent of those released in 1945 later were classified in the most-favorable outcome category. Some of the most recently released patients may have been in a convalescent state from which further improvement could be expected. Of the patients released earlier, many who made unsuccessful readjustments were returned to the mental hospital and became more or less permanent patients.

The aged had readjusted less successfully than other patients, 7 per cent, as compared with 27 per cent of other patients, being classified in the most-favorable outcome category. There appeared to be a tendency for middle-aged persons to have more favorable outcomes than younger or older persons. No persons 40-59 years of age were in the least-favorable outcome category. The sample size was too small to be certain of this tendency.

The proportions of persons in each of the two more-favorable outcome categories were the same for persons whose usual occupation was farming as for persons who were usually employed at skilled, semi-skilled, or unskilled occupations. A few of the former, but none of the latter, were described as requiring help with personal care. There were too few white-collar workers to permit definite conclusions, but those in the sample tended to make better readjustments than other occupation groups.

Persons whose formal education was not longer than 4 to 7 years were classified more frequently in the most-favorable outcome category than were either persons with no formal schooling or no more than a third-grade education or persons who had completed the eighth grade, including some with high-school and college training. A larger sample which would not require such broad groupings of educational level might be more revealing of the nature of the relation between formal education and outcome of hospitalization for mental illness.

Since admissions included the entire range of diagnoses of mental illness there were not enough patients with specific types of mental illness to permit the testing of the relationship between diagnosis and outcome. It was found that patients whose illnesses were reported to have had an acute onset were somewhat more successful in their readjustment than were those whose illnesses were described as having developed gradually.

CONCLUSIONS

While the investigations described here were intended to be primarily exploratory in character, certain findings emerged, some of which confirmed previous investigations and some of which might serve as hypotheses for future studies. A few findings have significance for policy in treating the mentally ill.

(1) *While Washington and Jefferson Counties differed widely in culture and racial composition, there was a remarkable agreement in the findings for the two counties.* Admission rates for different segments of the population varied in much the same way for the two counties. The distributions of diagnoses among patients admitted from the two counties were similar. The same proportions of patients had been released from the State Hospital at the time of the investigation, and of these the same proportions were still living. The proportions of those still hospitalized and those who died there were also similar; however, somewhat more of the Jefferson County patients had died in the hospital during first admission. These were disproportionately Negro patients. The outcome of hospitalization for released patients was not significantly different for the two counties. In most instances the scales, although constructed independently, were entirely comparable for the two populations. Where scales could not be combined it was usually because efforts to improve the scales modified the content of the Washington County scales for purposes of the Jefferson County study, not because the same scale items had to be treated differently in scales for the two counties.

(2) *There was a tendency for those segments of the population which constituted a disproportionately large share of the admissions to the State Hospital to have readjusted least adequately after their release from the hospital.* Women had lower admission rates than men and had better adjustment scores, though not better recovery scores, than did men. Admission rates were highest for the aged, who also made less adequate readjustments after release. The drop in admission rates in the years following age 40 was paralleled by the finding that persons from 40 to 59 years of age tended to have the most favorable outcome following their hospital experience. Married persons had the lowest admission rates and consistently more favorable readjustment ratings. Divorced and widowed persons had the highest admission rates and the least-

favorable readjustment. Single persons had high admission rates, which appeared to result from loss of opportunity to marry after the onset of mental illness since single persons were not over-represented among the patients at the onset of illness. Single persons at the time of interview had relatively poor outcomes, many persons single at release but with good recoveries at interview having married between release and interview.

White-collar workers had low admission rates (except in the case of Negro patients from Jefferson County) and had made better readjustments than other occupational groups, though there were too few to make this finding statistically significant. Those without formal education had the highest admission rates and less satisfactory post-hospitalization outcome than those with four to seven years of school but not less satisfactory than those with eighth grade education or better. Difference between whites and Negroes, while small, did not bear out the conclusion that low admission rates and favorable outcome went together. Whites in Jefferson County had slightly higher admission rate and made a slightly better readjustment.

It appears that the generally positive relationship between low admission rates and successful readjustment after the hospital experience may add substance to the view that admission rates represent real differences in vulnerability to mental disorder and not merely differences in the probability of seeking hospital care. It has been necessary to entertain the latter hypothesis because of the lack of data on incidence of mental illness among those not treated.

(3) *A study of the post-hospital adjustment of mental patients is a study of a selected group of patients not identical in their characteristics with all mental patients.* One-half of the admitted patients had died by the time of the follow-up investigation. These included a large proportion of those in their later years at the time of admission. Consequently the diagnoses associated with old age were under-represented among the released patients investigated. On the other hand, the latter were somewhat older than the still-hospitalized group. Since patients with organic psychoses had higher mortality rates than those with functional psychoses, and mentally deficient patients tended to remain hospitalized, the functional psychoses were over-represented among the released patients still living at the time of the investigation. The latter group were not unrepresentative with respect to the proportion

of males and females. While more males had died, more women remained hospitalized.

Some of the findings of the investigation suggest the need for certain measures in our care of the mentally ill.

(4) *The fact that patients who had waited no longer than one year to seek hospital admission made strikingly better post-hospital adjustments, and also had fewer hospital deaths than did those who waited longer, emphasizes the need for early treatment of mental disorder.* This need implies the advisability of public education toward the recognition of the symptoms of mental illness and acceptance of treatment for it. It also implies the availability of facilities for diagnosis, care, and treatment of the mentally ill. It should be noted that both of these are least available to those with greatest need—the poorly educated and those with low occupational status.

(5) *The large number of deaths among former patients due to accidents, violence, and suicide appears to indicate a need for continued contact with the released patients.* Especially the high suicide rate seems to show that some former patients who needed further treatment or custodial care did not receive it.

THIRTY-FOUR

Group Methods in Psychotherapy*

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THE TERM group therapy refers to all methods of treating psychiatric patients in groups under the leadership of a psychotherapist. Therapeutic groups may consist of children, adolescents or adults in or out of institutions who are in emotional distress presumably arising in large part from chronic disturbances in their relationships with other people. The goal of these groups is to ameliorate the suffering and improve the personal and social functioning of their members. The means to this goal are the emotional interactions of the members with the leader and each other, as they are determined by the members' habitual responses on the one hand and the leader's behavior and group mores on the other. This necessarily condensed presentation will consider group therapy of adult psychiatric outpatients only.

BACKGROUND

Group therapy appeared on the psychiatric horizon in the 1920's in the work of J. L. Moreno¹ and Trigant Burrow.² Both these men were somewhat outside the main stream of psychiatric thinking and practice and their influence was slow in being felt, although many of their ideas and methods have been incorporated into present day therapy. Moreno emphasizes the freeing of spontaneity through psychodramatic approaches. For Trigant Burrow mental disorder was essentially a disturbance in communication brought about by the individual's "privately cherished and se-

* From *Journal of Social Issues*, VIII (2nd issue, 1952), 35-44. Reprinted by permission of the author and the publisher.

¹ J. L. Moreno, *Psychodrama* (New York: Beacon House, 1946), Vol. I.

² T. Burrow, The basis of group analysis, or the analysis of the reactions of normal and neurotic individuals, *British Journal of Medical Psychology*, 8 (1928), 198-206.

cretly guarded" image of himself. The object of group analysis was to give the individual an opportunity to express himself as he really is by creating a social setting which stressed the socially pervasive character of these images. In the 1930's group therapy edged nearer to conventional medical and psychiatric thinking when J. H. Pratt,³ who had been treating tuberculosis patients in groups since 1905, began to treat groups of neurotics by a technique which stressed relaxation, suggestion, and education. At about the same time Paul Schilder⁴ began to experiment with psychoanalytically oriented groups of psychiatric outpatients. He saw group therapy as essentially an opportunity to analyze patients' ideologies.

Group therapy received its major impetus during the last war when lack of personnel forced psychiatrists to attempt to treat patients in groups. What started as a matter of necessity proved to be so helpful that, since the war, the use of group therapy in many forms has greatly expanded. Four major types may be distinguished. These are the therapeutic social club, the repressive-inspirational group, psychodrama, and the interview group.

The therapeutic social club⁵ is run along parliamentary lines, elects its own officers, collects dues and plans projects. The professional leaders, usually a psychiatrist and a social worker, select the members and attend all meetings but remain in the background. The main purpose of these groups is to increase members' skill in social participation as a means of combating the vicious circle of damaged self-esteem, social withdrawal, and further damage to self-esteem, in which they have been caught. The repressive-inspirational group is represented by Dr. Pratt's groups and Alcoholics Anonymous. Both lay the main stress on the emotional support derived from group morale. Some of these groups include didactic talks by the leader as bases for discussion. Psychodrama tries to free the patient's blocked spontaneity through a large variety of acting-out techniques with the aid of other patients and trained personnel, followed by a discussion in which the audience participates. The fourth type of group approach has

³ J. H. Pratt, Influence of emotions in causation and cure of psychoneuroses, *International Clinics*, 4 (1934), 1-16.

⁴ P. Schilder, Results and problems of group psychotherapy in severe neuroses, *Mental Hygiene*, 23 (1939), 87-98.

⁵ J. Bierer, A new form of group psychotherapy, *Mental Health*, 5 (1944), 23-26.

been variously termed interview group therapy, non-directive group therapy and analytical or analytically oriented group therapy. Groups following this approach try to foster face-to-face interactions in an atmosphere conducive to free and honest expression of feeling. The interactions are examined by patients and therapist with a view to exposing and correcting neurotic attitudes and achieving more mature ways of functioning.⁶ This type represents the main stream of group therapy with psychoneurotics, combining characteristics of the other three, and is therefore the focus of this paper.

SETTING AND LEADERSHIP

Group therapy is practiced wherever psychiatric outpatients are treated. Most facilities for outpatient treatment are directly or indirectly under medical auspices. They include mental hygiene clinics supported by local communities or federal agencies, psychiatric and medical outpatient departments of general hospitals, college student health services and, more recently, private psychiatric practice.

These settings imply that the group leader be either a physician—typically a psychiatrist—a psychiatric social worker or a clinical psychologist. Leadership of a therapeutic group may be shared by two trained persons, or, as in Moreno's psychodrama, by patients who as "auxiliary egos" influence the course of a psychodramatic situation under the director's guidance. To be successful, the leader of a therapy group must have a firm grasp of principles of individual psychotherapy and must be able to withstand the threats implicit in exposure to a group. Extensive familiarity with methods of effecting changes in members through manipulation of group forces or with phenomena of group functioning *per se* is less necessary. A therapist who is alert and free of anxiety soon becomes able to free himself from pre-occupation with problems of individual patients and to develop a sensitivity to the interplay of patients as it reveals their problems.

⁶ Florence Powdermaker and J. D. Frank, *Group psychotherapy—studies in methodology of research and therapy*, Cambridge: Harvard University Press.

MEMBERSHIP AND GROUPING

Group therapy has been used for patients with the whole spectrum of psychiatric disorders unaccompanied by gross brain damage, from minor reactions to situational stress to severe character disturbances and psychoses. It is also used in treating patients with organic illnesses with psychogenic components such as peptic ulcer and asthma, or with disabling psychological repercussions, such as epilepsy and diabetes.

Although a few patients seek group therapy on their own initiative, the great majority are referred by the medical practitioner, psychiatrist, or counsellor to whom they have gone for help, and they accept it initially, often with considerable reservations, solely on the basis that it has been prescribed. Preliminary interviews with the therapist to prepare the patient for group therapy are therefore desirable. These may range from a single talk lasting a few minutes, to a long series of psychotherapeutic sessions. In them the therapist tries to get some understanding of the patient's neurotic difficulties and gauge his suitability for group treatment. He also tries to acquaint him with the purpose and mode of functioning of the group, and to work through obstacles to participation, such as the patient's initial expectancy that he would be treated privately, his feeling that he cannot talk in a group, or his fear that he will have to reveal socially unacceptable impulses or activities.

From the standpoint of ultimate outcome it cannot be said with much assurance that any particular type of patient will or will not benefit from group therapy. Such knowledge awaits deeper understanding of the effective principles of different types of groups, better criteria of improvement, and development of a classification scheme more closely related than our present one to patients' characteristic ways of negotiating their interpersonal relationships.⁷ It has been noted, however, that patients with certain characteristics find initial group meetings stressful and others welcome them. The first type includes patients with socially unacceptable problems such as delinquencies and sexual deviations, those with a strong need for support from an authority figure or for prestige with regard to peers, or those who are excessively

⁷ J. D. Frank, *et al.*, Two behavior patterns in therapeutic groups and their apparent motivation, *Human Relations*, 5 (1952), 289-317.

timid, sensitive, or suspicious. The group situation is welcomed by patients with "social hunger" and by those who are moderately competitive or possess strong feelings of fear or anger toward authority figures. Such feelings are more readily expressed and dealt with in a group than in a private interview.

From the standpoint of the group, patients who are excessively aggressive, exhibitionistic, or garrulous put it under stress, while those who are socially facile, considerate, and seemingly interested in the problems of others are welcomed, at least at first. Feelings of patient and group to each other are often not reciprocal. For example, a socially hungry, garrulous patient may welcome the group but put it under great stress.

Valid knowledge concerning which patients should be placed in the same group is especially sparse. It is generally agreed that certain types of patients are too different to function well together in the same group. For example, psychoneurotics do not mix well with patients with antisocial character disorders, severely ill psychotics, or alcoholics. However, a group can successfully encompass a wide range with respect to such categories as age, social and economic status, intelligence, and education. Groups containing both sexes may be very successful.

Grouping in terms of similar bodily symptoms is generally agreed to be pointless. Many therapists, however, try to place patients with similar problems or conflicts in the same group.⁸ Others⁹ believe that such groups rather rapidly tend to become sterile and that a group needs the stimulation supplied by differences among its members. Many therapists group patients primarily on the basis of hunches as to whom they can work with successfully in the same group. The problem of "optimal distance" remains unsolved.

PROCEDURES

Mechanics. Although other types of group may include 25 members or more, the optimal number for an interview group seems to be five to eight. Most meet once a week for an hour and a half, though some meet as often as three times a week. Some

⁸ L. H. Loeser, *et al.*, Group psychotherapy in private practice, *American Journal of Psychotherapy* 3 (1949), 213-233.

⁹ A. Wolf, The psychoanalysis of groups, *American Journal of Psychotherapy*, 3 (1949), 525-558; 4 (1950), 16-50.

therapists add no new members; others replace members who drop out. Some groups have a definite termination point, the shortest duration being about six weeks. Other groups continue indefinitely. Under the latter conditions some patients drop out early because the group is not what they want, or conversely because they have achieved what they desired. A considerable proportion reach maximum benefit within six months to a year. Others seem to remain indefinitely and incorporate group therapy into their pattern of living much as they would going to church.

Observers. Observers are frequently used to help the therapist keep track of the events of a meeting, including especially the effects of his own behavior. Observing therapeutic groups is excellent preparation for leading them. Observers may sit in the back of the room and confine themselves to recording the meeting or may participate as additional therapists. They are seldom used for "feedback," i.e., reporting their perceptions of what is occurring to the group during a meeting, because this function is usually reserved to the therapist. Usually the group's attitude toward the observer accurately reflects that of the therapist. If the latter ignores him, the group soon accepts him as part of the furniture, and even several observers may have no detectable effect on the meeting's course.

Special techniques. Many devices have been used to facilitate and channelize interactions among members. Perhaps the most elaborately developed techniques are those of psychodrama.¹⁰ Others are analysis of dreams, "going around," in which each patient is asked to free-associate about the next,¹¹ discussions based on lectures or printed materials,¹² relaxation exercises,¹³ discussion of sociometric data previously obtained from the patients,¹⁴ and playback of portions of previous meetings.¹⁵ Many therapists, however, prefer to leave the situation unstructured and to rely solely on the patients' spontaneous participation.

¹⁰ Moreno, *op. cit.*

¹¹ Wolf, *op. cit.*

¹² J. W. Klapman, *Group psychotherapy: theory and practice* (New York: Grune and Stratton, Inc., 1946).

¹³ Pratt, *op. cit.*

¹⁴ H. Coffey, et al., Community service and social research—group psychotherapy in a church program, *Journal of Social Issues*, 6 (1950).

¹⁵ W. McCann and A. A. Almada, Round-table psychotherapy: a technique in group psychotherapy, *Journal of Consulting Psychology*, 14 (1950), 421-435.

BASIC ASSUMPTIONS

The goal of all psychotherapy is to free the patient's spontaneity and capacity for emotional growth, so that he may become more comfortable, effective and emotionally mature. The means to this end is the creation of a particular type of interpersonal relationship through which the patient can become aware of and correct the distorted perceptions and maladaptive responses springing from early life experiences, which have hampered the normal processes of growth. Characteristics of the psychotherapeutic relationship which facilitate these processes are permissiveness, support, stimulation, verbalization and provision of opportunities for "reality testing," that is, for trying out the effects of one's responses. Therapeutic groups may be profitably considered with respect to these interrelated functions.

1. *Permissiveness.* Most neurotics suffer from too stringent internalized controls in the form of feelings of guilt and fear of others' censure which block self-realization, so that in the first instance the psychotherapeutic situation must convey to them a feeling of permissiveness. Permissiveness is an integral part of the group mores which the therapist tries to establish. It is enhanced by the safety of the group situation and the opportunities for escape if tension becomes too threatening.

2. *Support.* Permissiveness must be accompanied by some sort of guidance for the patient as he attempts to explore and modify his attitudes. This guidance is implicit in the selective emotional support offered by all forms of psychotherapy. Support is also necessary to combat the paralyzing loss of self-confidence from which many emotionally ill patients suffer. The therapeutic group is actively supportive in its members' efforts to understand and appreciate rather than judge each other. A patient's morale may be strengthened simply by feeling himself a member of such a group, sharing its goals and standards and believing in the efficacy of its methods. A patient may be encouraged by seeing others improve and his self-esteem may be enhanced by the knowledge that he is helping them. Demoralizing feelings of difference and isolation are combatted by the discovery that one's feelings and problems are shared by others, and by finding oneself taken seriously by one's peers. As one patient put it: "In a (therapeutic) group I can talk and be listened to. Elsewhere people fit what

I try to say into their own thoughts." Even anger may be supportive if it implies to a patient that others take him seriously enough to get angry at him, especially if the object of the anger feels it to be directed toward his neurotic behavior rather than himself as a person.

3. *Stimulation.* Neurotic responses must be expressed in the therapeutic situation if they are to be changed by it. The group stimulates such expression in addition to offering permissiveness and support. Members' feelings may be stirred up, for example, by direct contagion, by associating to the problems of others, by envy of another member's progress, by rivalry for the doctor's attention, by antagonisms arising from conflicting values, and by transference reactions in the narrower sense, for which the variety of personalities present offers abundant opportunity.

4. *Verbalization.* Since the verbal apparatus is our chief analytical tool, putting feelings into words is an important, perhaps an essential prerequisite to clarifying and changing them. The free give-and-take of group discussion, the efforts to make one's position clear, to win arguments, to respond to others' interpretations of one's behavior, and so on, often are powerful incentives to therapeutically useful verbalization. This is also facilitated by the group code which demands examination of feelings rather than mere acting out.

5. *Reality testing.* All psychotherapeutic situations contain elements of novelty and familiarity which facilitate testing old and new attitudes and ingraining the appropriate ones through practice. The novel aspects, some of which are implied in the discussion of permissiveness, support, and stimulation, help the patient to gain new insights into his attitudes, especially when others fail to respond as he expects. The familiar aspects allow him to test his responses on the spot and transfer what he learns to everyday life. The therapeutic group contains a useful blend of the familiar and the new. For example, it is structured somewhat like a family, containing sibling and parent figures, and group members exemplify important real life roles. Thus, a worker having difficulty with bosses may in a group be exposed to other workers with attitudes similar to or different from his own, and to employers as well. This similarity to real life goes along with significant differences—for example, a permissiveness which attenuates the penalty for failure and the relative directness and honesty of the members' reactions which help each to see how his

behavior is perceived by others. These qualities make the group especially useful for testing and improving social skills in which many psychiatric patients are seriously deficient.

These properties are closely interrelated. For example, improvement of a member may encourage some and may stimulate envy in others. Antagonisms may be not only stimulating but also supportive in that through them members learn that they can maintain a position despite opposition, that they have allies, or that a relationship may survive a battle or even be strengthened by it.

GOALS AND ACTIVITIES OF THE THERAPIST AND THE MEMBERS

The general course of a therapeutic group as well as the activities of its members are markedly influenced by the therapist. Initially, patients' actions are largely determined by their more or less conscious perception of what the therapist wants, and their reactions to this; later their behavior is increasingly influenced by the group mores, which he has been primarily responsible for establishing.

Depending on theoretical orientation, therapists may emphasize different goals. For example, therapists of social or inspirational groups aim primarily for cohesiveness and smooth functioning, while those of analytically oriented groups hope for as much emotional stress among members as the group can master without disruption. The permissive atmosphere they foster facilitates emergence of a great variety of interactions and content and accompanying emotional tensions. At first patients are primarily concerned with exploring the group situation and presenting themselves as they wish the doctor and group members to perceive them. Symptom recitals, inquiries as to procedure and attempts to appraise each other and to establish similarities and differences predominate. In the course of these interactions patients indicate how they consciously perceive themselves in relation to others—their *conscious* social roles. In addition, the effects of their behavior on each other of which they are not aware give clues as to their *unconscious* social roles.¹⁰ Tolerance for tension is low, with ready escape into irrelevancies and generalities.

In early meetings the therapist tries to encourage the development of a group in which all members are heard with respect.

¹⁰ Coffey, *op. cit.*

Honest expression of feelings is fostered, provided the patient is prepared to examine these feelings rather than merely act them out. Emphasis is placed on studying members' reactions to each other rather than on events in their individual pasts, or events outside the group. The therapist may transmit information which he believes will help all the members, such as the relationship of emotional state to autonomic disturbances. He also may find it advisable to protect patients who expose themselves compulsively before the group is ready to support them, or who must maintain an air of superiority and are threatened when the other members undermine this. He occasionally may have to come to the rescue of the scapegoat or isolate. It may be necessary for him to remove blocks to interaction by examining group process, as when, for example, a group bogs down in a silence caused by shared feelings toward the therapist they fear to express.

From the start the therapist works to wean the group from its initial dependence on him. At first members regard each other mainly as rivals for his help. Part of his goal is to help them perceive the group situation as a source of help of which he is just one aspect, albeit an important one. As the group develops, patients express their feelings about and to each other and the leader more directly and become increasingly able to make penetrating and helpful interpretations based on shared emotional problems or similar life experiences. Tolerance for tension increases and intense, prolonged emotional interplays may occur. After the group standards are well established and strong relationships among members have developed, the therapist can become less active and confine himself to helping the members to become fully aware of their reactions. Occasionally he may have to intervene decisively if the group reaches an impasse or if feelings rise to a point where the patients are no longer able to handle them.

Throughout the group's course many group phenomena occur which may foster or hinder therapeutic progress of the members, depending on the particular circumstances. These include rallies around a topic, monopolies by a single patient, group silences, rivalries for the doctor's attention, feuds (often with sidetaking), scapegoat formation, and transference reactions, to mention some common ones.¹⁷

The content of group discussion may include apparent irrele-

¹⁷ Powdermaker and Frank, *op. cit.*

vancies such as current events, as well as patients' dreams, symptoms, past experiences, contemporary experiences outside the group, and reactions to each other in the group. Although the last are usually the most fruitful for helping patients to understand and modify their attitudes, any content can serve as a vehicle for important feelings. For example, a casual discussion between two housewives about how they spent the day, which an academician in the group was unable to join, caused an emotional upheaval in the latter leading him to accuse the whole group of being stupid. Since one of his major problems was that he secretly thought other people were stupid but had never been able to tell them so, this proved to be an important corrective emotional experience for him.¹⁸

Not infrequently, apparently unrelated remarks of several patients reflect a common concern of the group.¹⁹ Thus experienced therapists pay less attention to what is said than to how it is related to the immediate group situation.

SUMMARY

Despite wide variations in the goals and modes of functioning of therapeutic groups, certain generalizations about them may be ventured. All have no purpose beyond producing or facilitating attitudinal changes in their members. In this sense there is no group goal other than to function in such a way as to realize as fully as possible the individual goals of its members.

All therapeutic groups are structured to the extent of having a leader who chooses the members, to whom they look for guidance, and on whom they feel more or less dependent. Within the limits set by the personal characteristics of the members, the leader determines the structure and mode of functioning of the group, including the degree of self-direction and spontaneous participation. All therapeutic groups have sets of standards and modes of procedure, differing according to the school of thought of the therapist, but aimed at creating the most favorable setting for modification of attitudes in a direction considered therapeutically desirable. Most standards favor honest emotional expression, ex-

¹⁸ J. D. Frank and E. Ascher, Corrective emotional experiences in group therapy, *American Journal of Psychiatry*, 108 (1951), 126-131.

¹⁹ H. A. Ezriel, A psychoanalytic approach to group treatment, *British Journal of Medical Psychology*, 23 (1950), 59-74.

amination of feelings and respect for others' viewpoints and actions. Most procedures stress analysis of the interpersonal relations between members to bring neurotic distortions to light and also consideration of personal problems to the extent that they are shared by several members. Processes involving the group as a whole come into focus only when relevant to the attitudes or therapeutic progress of the members, as for example when they express a collaborative form of resistance, or impede the free flow of interaction. What is considered to be the optimal degree of cohesiveness varies widely, but all would agree that the group must be cohesive enough to give its members emotional support. Many feel that too much cohesiveness inhibits therapeutically useful emotional tensions.

The level of intimacy of members is high in the sense that very personal matters are bared and feelings freely expressed, but low in the sense that there are no shared long term activities, responsibilities, or goals.

In short, the therapeutic group is created by its leaders to serve as a medium in which its members may, through their interactions, resolve their neurotic difficulties and achieve emotional growth.

The Role of Psychiatric Social Work in Mental Health*

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IN ORDER to understand the relationship of psychiatric social work to mental health and mental illness a number of presuppositions have to be stated and examined:

1. Psychiatric social work is a branch of social work and therefore partakes of the characteristics of social work as a professional discipline.

2. Psychiatric social work is practiced primarily by social caseworkers. Recently, however, social group workers have begun to work in psychiatric settings together with social caseworkers.

3. Psychiatric social work operates in "direct and responsible relationship" to psychiatry, i.e. in a team relationship.

4. Psychiatric social work is practiced in institutional arrangements called psychiatric settings, notably hospitals and clinics.

5. The focus of attention of psychiatric social work is the patient, the patient's family, and the patient's community.

6. The primary emphasis of psychiatric social work is the diagnosis and treatment of mentally ill or emotionally disturbed patients. To this has been added recently an emphasis on mental health education, on teaching of personnel in related disciplines such as medicine and nursing administration, on consultation, and on research. There has also been a development of community organization for mental health in which psychiatric social workers are active.

7. The degree of professional status, of professional organization, and of occupational definition of function is much higher in psychiatric social work than in any other branch of social work.

* Prepared especially for this volume.

There are discernible elements in psychiatric social work which constitute a subculture within the culture of social work.

It is desirable from the outset to define mental health and mental disorder for the purposes of this paper. If mental health (as in the World Health Organization definition of health) is viewed as "the presence of physical and emotional well-being," little clarity can be gained as to the difference between mental health and other areas of health. This does not negate the advantage of the WHO concept of health, which eliminates an artificial distinction between physical and mental health. If, however, it is necessary to examine the role of a given profession with reference to a more or less well-defined series of disease entities, it would seem preferable for purposes of our discussion to disregard this more dynamic concept of health and mental health and be content with a more traditional definition such as the following: *Mental health is a condition and level of social functioning which is socially acceptable and personally satisfying.* Consequently, mental illness can be defined as those conditions or levels of social dysfunctioning which are either socially unacceptable or personally dissatisfying or both. This definition intentionally evades the inclusion of specific mental disorders diagnosed under the headings of neuroses, psychoses, and psychopathic conditions. The reasons for this are threefold:

1. The psychiatric social worker, as all social workers, is concerned with psychosocial factors in emotional disturbances and mental disorders, regardless of whether or not a clinical diagnosis has been attached to them.
2. Psychiatric social workers do not usually depend upon a psychiatric diagnosis to determine whether or not they should become professionally active, nor are they concerned with the not-infrequently encountered difficulties of classifying a set of symptoms within an established diagnostic category.
3. The theoretical framework of psychiatric social workers, unlike that of psychiatrists and psychologists, presupposes their looking at the social manifestations of psychosocial dysfunctioning. In other words, the psychiatric social worker is concerned with social and/or psychological events in the patient's life which have had an effect upon the patient's social functioning. These events may cause him to behave in such a way that he can no

longer fulfill his social role as husband, breadwinner, employer, employee, etc., either to his satisfaction or to the satisfaction of the persons and groups with whom he is interacting. Also, the social or personal dissatisfaction with certain behavior manifestations must have reached a sufficiently high degree to warrant intervention. The intervention is either (1) voluntary, i.e. the afflicted person constitutes himself a patient and seeks treatment, or is (2) socially sanctioned and comes from the community, i.e. he is more or less forcibly brought to the status of becoming a patient.

The theoretical framework of the psychiatric social worker presupposes further that he is not concerned with the treatment of clinical states or entities, such as "hostility," "aggression," or "anxiety neurosis" or "schizophrenia" per se. What calls him into action is the presence of the social dysfunctioning which is the result of such conditions. This includes the social dysfunctioning not only of the patient but also of the patient's family. In all instances the patient is viewed as a member of the family, a member whose condition affects the family balance and is affected by it, hence has a bearing upon the social functioning of every member of the family. For instance, in the case of a schizophrenic patient for whom long-term hospitalization is in store, the psychiatric social worker will be active in helping the patient fit into the hospital community to derive maximum benefit from it, and will help the hospital personnel, especially ward attendants, to gain a better understanding of the patient and the effect of the disease upon his functioning as a member of the hospital community. In addition he will devote major effort to working with the patient's family so as to maintain or restore for them a level of social functioning which will enable them to continue to operate as a unit despite the absence and illness of one of their members and also enable them to be of maximum therapeutic assistance to the absent member.

Although the psychiatric social worker is concerned with the social effect of certain clinical and subclinical conditions it does not follow that his treatment is concerned with the social symptoms of social dysfunctioning exclusively. In order to determine what to treat, the psychiatric social worker, like all social workers, has to make a psychosocial diagnosis, which means he has to assess from the social and psychological circumstances of the patient's life what is possibly related to his present predicament.

He has to be aware, for example, that social events such as unemployment, death, or illness may have merely social or merely psychological repercussions. For instance, the death of a child's father and his ensuing absence from the home and from membership in the family unit may result in both psychological deprivation, such as lack of identification, and social deprivation, such as lack of financial support. It is not easy to draw a fine line between the psychological and the social effects of social events, especially those of childhood. In keeping with a broad psychoanalytic orientation it may be said that most social events which occur in childhood will be internalized by the child and in turn manifest themselves in his psychological make-up and functioning. Conversely, many childhood psychological occurrences tend to manifest themselves through the adult's social behavior. Therefore, the psychiatric social worker will have to assess to what extent social dysfunctioning is the result primarily of social or of psychological events, and to decide whether a social or a psychological reconstruction is indicated. The formulation of a psychosocial diagnosis through such an assessment then leads to the establishment of a treatment plan which includes both specific treatment goals and treatment methods. The treatment plan, in terms of both goals and methods, is a function of the psychosocial diagnosis.

Against this background it will now be possible to discuss one by one the implications of the presuppositions listed above:

FIRST PRESUPPOSITION

Psychiatric social work is a branch of social work and, therefore, partakes in the characteristics of social work as a professional discipline.

The field of social work can be divided into three major methods: social casework, social group work, and community organization for social welfare. Each method has its characteristic techniques but their common purpose is to enable individuals and families to function in their assigned societal roles. Commonly used in all three methods—since each of them is practiced in structured organized settings and not by independent practitioners, and since each of them has to rely upon the discovery as well as the use of new knowledge—are the techniques of administration and research.

The term "psychiatric social worker," in contrast to the term "psychiatric caseworker" or "psychiatric group worker" or "psychiatric community organizer," implies the notion that a psychiatric social worker uses all of the three methods of social work in the course of his daily practice. This thesis, however, is not in keeping with reality. The bulk of psychiatric social work is carried on by caseworkers, who work in psychiatric settings such as hospitals and clinics. They share with all other social workers a characteristic feature of the profession of social work, namely that they are employees of agencies and not independent practitioners. Recently, in some pioneering clinics, efforts have been made to add psychiatric group workers to the staff, and psychiatric group work experiments have also been conducted with certain groups of patients in hospitals. This would indicate that the term "psychiatric social worker" is tending to become more appropriate, since it describes more than the methods of social casework.

The term psychiatric social worker can be explained historically: It stems from the synonymous use of the term social work with the term casework which was current during the twenties and thirties. For the same reasons caseworkers who practice in medical settings are called medical social workers. The methods of group work and community organization are relative newcomers as distinct methods in social work and their concepts have been less well developed than those of social casework.

In recent years, however, the practice of psychiatric social work has undergone certain changes which warrant, more than before, the appropriate use of the term psychiatric social work. These changes were partly brought about by the experience of psychiatric social workers in the war effort, where many were engaged in helping soldiers adjust to the exigencies of the military community. This required a new definition of the role of the psychiatric social worker vis-à-vis the community. It has always been part of the professional philosophy of social work to be primarily concerned with the welfare of the individual. This meant in some instances to help the individual modify the environment to obtain relief; in other situations to help him accept a social reality with which he was in conflict either in the legal or the social sense; or to help him in both these needs. The overruling ethic of social work postulates that the individual is all-important. This means that social mores and their power must

be examined against their mental-hygiene values, and that the individual should be helped to abide by the mores if they are consistent with these values or helped to change them if they are in contradiction with these values.

Military psychiatric social work¹ meant helping patients to accept the validity of the war effort and the military establishment. The experiences in helping soldiers come to grips with the exigencies of the military community led to a new look at the community and to psychiatric social workers' relation to it. This was reinforced by another set of developments which occurred in the wake of World War II: the passage of the National Mental Health Act of 1945, and the subsequent establishment of mental health authorities in many states of the union. The war had shown the incidence of mental disorder and had increased the awareness and acceptance of mental disorders. Consequently we witnessed a development of mental hygiene clinics in many states. The establishment of mental hygiene clinics in many communities brought social workers into contact with many community leaders and groups both for purposes of interpretation of function and recruitment of staff. It led to a stronger interest in perceiving the interdependence of community services and to the psychiatric social worker's playing a more active role in strengthening the coordination of community services. It also meant that psychiatric social workers became more alert to community forces, status groups in the community, socio-economic pressures and stratifications, and the conglomerate of social, psychological, and economic attributes which is called "community climate." The other set of forces which brought psychiatric social workers in closer touch with the community was the fact that a hard new look was taken at the relationship between the state hospital and the community.

The state hospital rediscovered an old but partly forgotten truth that it should not serve as a dumping-ground for pathological and more or less incurable patients but is part of the community and serves as its treatment center. There was a realization that part of the state-hospital treatment program is to fashion ties between the patient and the intramural as well as the extramural community. This caused the establishment of foster home,

¹ Henry S. Maas, editor, *Adventure in Mental Health, Psychiatric Social Work with the Armed Forces in World War II*, New York, Columbia University Press, 1951.

rehabilitation, and after-care programs which were designed to strengthen the ties between the patients and their old link to their homes.

This post-World War II mental-hygiene movement, in which many psychiatric social workers participated, led to a clearer concept of the role of the psychiatric social worker, not only as a member of the therapeutic team but also as a stimulator of community services. Hand in hand with this (and probably caused by the same social factors) was a new conception of the psychiatric social worker's role in the psychiatric hospital. In addition to seeing himself as helping the patient to adjust to the regimen of the hospital and helping the patient's family to understand the hospital function and adjust to the absence of the patient, the psychiatric social worker conceives of his role as a co-ordinator of all the hospital services on behalf of the patient. This function of community organizer within the microcosm of the hospital and the macrocosm of the larger community has added a dimension to the present-day psychiatric social worker which justifies the use of the term *social work*.

SECOND PRESUPPOSITION

Psychiatric social work is practiced primarily by social case-workers. However, recent trends indicate the development of group work in psychiatric settings. In 1952 there were approximately 2,200 social workers in psychiatric settings, 1,400 in mental hygiene clinics, and 817 in hospitals for the mentally ill.²

PSYCHIATRIC SOCIAL WORK IN HOSPITALS

Psychiatric social work started in psychiatric hospitals in the beginning of this century. The first psychiatric social workers were employed in 1905 in the neurological clinics of the Massachusetts General Hospital in Boston, and in Bellevue Hospital and Cornell Clinic in New York City.³ So-called "after-care agencies" were added to the psychiatric hospital staff for the purpose of assisting the patient in his return to the community. By 1918

² Tessie D. Berkman, Director, Research Study, *Practice of Social Workers in Psychiatric Hospitals and Clinics*, New York, American Association of Psychiatric Social Workers, 1953.

³ Ruth Irelan Knee, "Psychiatric Social Work," in *Social Work Yearbook* 1954, New York, American Association of Social Workers, 1954.

psychiatric social work, which received its name in 1913 from Mary Jarrett, was used in several state as well as private hospitals. Berkman, whose study (referred to above) constitutes the most recent up-to-date report on psychiatric social work practice, finds that there is little uniformity of practice but that the social services are in large part determined and sometimes prescribed by the psychiatrist, and include responsibility toward both the patient and his family. The patient is helped to understand and use the hospital and its facilities. Specific services may be required at the time of admission, at the time of discharge, and at certain times during the period of hospitalization when treatment considerations may require a shift in the hospital regimen. The services may be tangible or intangible, or both. The tangible services for the patient run the gamut of helping him find reading matter, writing letters, securing information about legal matters (for instance, pensions), interpreting to and establishing liaison with community persons (for instance, landlords), foster-home-care services, discharge-planning including referral to a community agency and help in securing employment. The intangible services consist of such services as helping the patient accept his illness and providing help with family relationship problems. The latter services were also frequently given to the patient's family and, together with certain tangible ones such as help with legal problems, constituted the bulk of the psychiatric social worker's activities on behalf of the family. Berkman reports four categories of intangible and two categories of tangible services.⁴ The intangible services are: (1) interpretation of the psychiatric illness of the patient, of his treatment, and of the problems and relationships growing out of the illness; (2) assistance with problems of family relationships; (3) supportive treatment; and (4) psychotherapy. The tangible services are: (1) help with concrete, practical problems; and (2) interpretation of outside agencies and liaison with them.

The purpose of these services was essentially supportive, that is, they were designed to maintain or heighten the reality perception of the patient and the level of functioning of the family to the end that, independently or in interaction, patients would derive therapeutic benefits from these services. Hence all these services, including the activities of the psychiatrists, are therapeutic.

⁴ Berkman, *op. cit.*, p. 42.

PSYCHIATRIC SOCIAL WORK IN PSYCHIATRIC CLINICS

While in psychiatric hospitals social workers might be assigned certain aspects of treatment at a given point of time, for instance at admission or at discharge, Berkman found that the psychiatric social worker in the clinic was active from the point of intake on, in providing the services of the clinic to either the patient or his family both in clinics for children and clinics for adults. An important difference between the hospital and the clinic psychiatric social worker, however, is the difference in the role of the psychiatric social worker in relation to the psychiatrist. While in the hospital it is the psychiatrist who is legally responsible for treatment and delegates certain aspects of the treatment to the psychiatric social worker, in the clinic the team members, which in addition to the psychiatrist and social worker include the psychologist, operate on a more equalitarian basis. This is evidenced by the practice of holding diagnostic and intake conferences. After data are collected by all three members of the team, a sharing of these data leads to the formulation of the treatment plan and to the joint decisions as to which of the three members of the team, the psychiatrist, the social worker, or the psychologist should be given major treatment responsibility and in which area. There are three major patterns of collaboration between psychiatrists and social workers:

1. The psychiatrist treats the patient and the social worker treats the relatives. This is the classic pattern of the child-guidance clinics.

2. The psychologist treats the patient, and the social worker also provides certain tangible services such as referral of the patient to the community agency. This is the pattern of the clinic attached to a hospital and comes close to the pattern of the relationship between psychiatrist and psychiatric social worker in the hospital.

3. The patient is treated by the social worker. In some instances relatives are also treated by a psychologist. The special characteristic here is that the patient as well as the relative is treated by a non-psychiatric member of the team.⁵

In further contrast to the role of the psychiatric social worker in the hospital, the social worker in the clinic provides very few tangible services but is active primarily in providing relation-

⁵ *Ibid.*, p. 61.

ship services, i.e. he is engaged in helping patients and families to improve disturbed relationships with each other through focusing upon their attitudes and feelings. His relationship to the psychiatrist is often characterized by the description that the psychiatric social worker operates under the "supervision of the psychiatrist or in consultation with the psychiatrist." Although supervision implies authority, the description is indicative of psychotherapeutic or quasi-psychiatric functions on the part of the psychiatric social worker in the clinic. This is not necessarily widespread practice, but it is a significant trend.

SOCIAL GROUP WORK IN PSYCHIATRIC SETTINGS

In the 1950 study by Berkman, it was found that 12% of all social workers included in the study used the group method of providing services to patients or relatives.⁶ The 1940 study by Lois M. French⁷ makes no mention of such a method. This method has come to be used by a number of professional disciplines outside of social work such as child psychiatry, and also by social workers who designate themselves as group workers as well as caseworkers. In hospitals the group method is used primarily for such purposes as orienting groups of patients to the hospital, providing information about resources and services in the hospital, and preparing patients for leaving the hospital. These services, although directly related to the patient's welfare and treatment, are considered as secondary to treatment.⁸ The main purpose of group work in the hospital is to help the patient adjust to a changed social and environmental situation. In clinics, on the other hand, the services provided by the group method are often referred to as therapeutic. The difference in definition of therapy in hospitals and clinics which is implied here should be noted. The clinic group worker seems to be primarily concerned with feelings and attitudes; hence the use of the group method in play with children and in helping groups of mothers, through discussion of their children's problems, to reduce some of their anxiety or guilt.

⁶ *Ibid.*, p. 68.

⁷ Lois Meredith French, *Psychiatric Social Work*, New York, The Commonwealth Fund, 1940.

⁸ "Psychiatric Group Work," in *Education for Psychiatric Social Work, Proceedings of the Dartmouth Conference*, New York, American Association of Psychiatric Social Workers, 1950.

However, the provision of services through the group work method in the hospital does not directly aim at modification of feelings and attitudes, although it may indirectly have that effect, or it may help the patient and the family to be more accepting of the hospitalization and by so doing make them more receptive to the other aspects of the treatment program. In other words, in hospitals the use of the group method may have indirect or secondary therapeutic consequences. This implicit hierarchical definition of what is therapy has a great deal to do with the prevailing confusion of the differences in function between the psychiatrist and the psychiatric social worker in the areas of intangible services, which will be discussed in connection with the next topic.

THIRD PRESUPPOSITION

Psychiatric social work functions in direct and responsible relationship with psychiatry.

The fact that psychiatric social workers use the same methods as all social workers, particularly caseworkers, has made it difficult to define whether psychiatric social work is a specialty in social work and if so in what way it is different from other forms of social casework practice. It is conceded generally that at the present time the psychiatric social worker does not know more about the supporting social sciences or more about psychiatry and psychopathology than any other social worker. In fact, most schools of social work emphasize that he receives the same professional training as any other type of social worker, the only difference being that his second year of field-work placement is in a psychiatric agency instead of in a family or children's agency or a court or department of public welfare. Historically, however, the content of professional education which is now generally that of most caseworkers was developed originally for psychiatric social work alone.

There is actually only one distinguishing characteristic of the psychiatric social worker: that is the fact that he works as a member of a team and in a setting where social service is not the exclusive treatment method. This is true regardless of whether the social worker works with the patient or with the patient's family. It is the collaborative nature of psychiatric social work which characterizes its role in the hospital and in the psychiatric clinic. This distinguishes him from the social worker in the family or

children's agencies and from the social worker in the public welfare department.

However, this feature which distinguishes psychiatric social work from the above-mentioned types of social work does not differentiate it radically from medical social work. The medical social workers provide medical care in conjunction with a medical practitioner. The closeness of these two specialties is exemplified in the fact that until the early 1920's medical and psychiatric social workers were members of the same professional organization, the Association of Hospital Social Workers. Indeed, there was good reason for this, because both practiced in the setting of the hospital. The advent of mental-hygiene clinics for children and adults, however, introduced an element of difference, for here the service is essentially a shared one rather than an adjunctive one. This led to the establishment of a new common denominator; not the team relationship alone, but the team relationship with psychiatry. In turn that gave birth to the official American Association of Psychiatric Social Workers definition that a psychiatric social worker is one who works in a "direct and responsible relationship with psychiatry."

In the preceding section the different patterns of relationship between social worker and psychiatrist have been detailed. The variety in this pattern is perhaps the major difference between psychiatric social work and medical social work, where only the one major pattern of relationship seems to prevail: The physician is legally responsible for the course of treatment and delegates to the medical social worker those areas of treatment which are within the sphere of psychosocial dysfunctioning. We have seen that this type of relationship is only one of the several possible patterns of team work between psychiatrist and psychiatric social worker.

The characteristics of the specialization of psychiatric social work can therefore be said to consist of the adaptation of the principles of social casework and social group work to practice of these methods within the "environment in the psychiatric setting."

This view of psychiatric social work as essentially casework practiced in a psychiatric setting has not always been held. In 1929 two different definitions of psychiatric social work were extant. One used the criterion of the setting and the other postulated a criterion of superior knowledge of psychodynamics with a re-

sulting superiority of skill in casework. Although French⁹ made an attempt in her 1940 study to clarify the meaning of psychiatric social work the problem continued to exist and led in 1948 to the following clarification by Ethel L. Ginsburg:

Although to some, the meaning of "psychiatric social work" is crystal clear and requires no redefinition, there is sufficient unresolved conflict on this score to warrant further clarification here. The conflict grows out of a confusion, in part semantic, as to the precise meaning of "psychiatric" when attached to "social worker." Does it mean that social workers thus designated know more psychopathology or are more dynamically oriented than other social workers? Does it mean that psychiatric social workers are those who work with psychiatrists, as opposed to those who do not? Or does it mean that the psychiatric social worker is one who works in a psychiatric setting? . . . In the end, it may be that words will provide the solution. "Psychiatric" can be used accurately only in relation to setting. It should not be confused with "dynamic." . . . The difference between the psychiatric social worker and his colleagues is one of setting, not of quality.¹⁰

FOURTH PRESUPPOSITION

Psychiatric social work is practiced in institutional arrangements called psychiatric settings.

The psychiatric social worker typically is an agency employee. He is a member of the professional staff in one of two types of setting, the psychiatric hospital and the clinic. Berkman¹¹ found that of the psychiatric hospitals 95% were tax supported and 5% were privately supported. Of the clinics 15% received their support from federal sources, 50% were supported by state, county, or municipal funds, and 35% were supported by private funds. Many of the clinics and hospitals other than those supported by federal funds received their support through a combination of public and private sources.

As to the administrative structure it was found that the majority of the hospitals were independent units, whereas only a small number of them were part of a general hospital. Among clinics, however, 45% were found to be operated by a parent organization

⁹ Lois Meredith French, *op. cit.*

¹⁰ Ethel L. Ginsburg, "Psychiatric Social Work," *Orthopsychiatry 1923-1948—Retrospect and Prospect*, New York, American Orthopsychiatric Association, Inc., 1948, pp. 470-472.

¹¹ Berkman, *op. cit.*, p. 6.

such as a hospital, a school, a court, or a social agency. The majority—55%—were independent (although this figure includes 15% of all clinics under federal auspices, largely under the Veterans Administration).

There were at the time of the study about 1500 agencies, hospitals, and clinics engaged in the treatment of mental disorders. Most of the hospitals were established during the nineteenth century with additional ones created by the Veterans' Administration after World War I. The great upswing in outpatient facilities, either as part of a hospital or independent, occurred after 1945. It is interesting, for instance, to note that 77% of the 223 hospitals included in the Berkman study were established before 1934, whereas 74% of the clinics comprised in the study were created after 1934; and that since 1945 two out of three clinics established were tax-supported.

The professional team in the hospitals and clinics includes the psychiatrist, the psychiatric social worker and in most instances a psychologist (90% of the hospitals and 93% of the clinics). In addition there are medical specialists other than psychiatrists and non-medical specialists such as nurses and occupational, recreational, physical, and musical therapists. The Berkman study found that the median ratio of psychiatric time to social-work time was two to one in the hospitals and almost the reverse in the clinics—seventeen social workers to ten psychiatrists. However, this is largely due to the fact that in most clinics 81% of the psychiatrists were part-time workers whereas in the hospitals they were mostly full-time personnel. In both types of settings the social worker usually works on a full-time basis.

Within the psychiatric setting different structures prevail as far as the social worker's functioning in relation to that of other services is concerned. Again, the differences between psychiatric hospitals and clinics are striking. In the hospital, social service functions characteristically as a unit or a department.¹² This is much less true in the clinic, where the social worker is identified with all the other members of the team and there is no separation. In hospitals the head of the social service is called a chief social worker and holds his position by virtue of a formal assignment or classification. In clinics this position, where it exists at all, is a less formal and a less distinctive function. In the clinic the social worker is identified with all facets of the clinical program and

¹² *Ibid.*, p. 18.

not just with the social service program, as in the hospital. The over-all structuring of the hospital into many departments, the size of the hospital, the fact that the hospital is the older of the two organizations, tend to account for the differences. In addition, there are some differences in the quality and type of the team relationship between psychiatric social worker and psychiatrist. In the clinic there is a higher degree of equality than in the hospital.

The functions of the social worker in both types of organization are directed towards providing services for both client and family. It is noteworthy that the Berkman study shows a differentiation of the function of psychiatric social work in a hospital and in a clinic. For instance, taking a history, engaging in after-care casework with patients and relatives, working with them during hospitalization as well as at the time of admission, are typical hospital tasks. In clinics no such distinction of the function is made except for intake. The emphasis there is on a continued casework relationship with the patient, with his family, or both.

FIFTH PRESUPPOSITION

The focus of attention of psychiatric social work is the patient, the patient's family, and the community.

This topic has already been covered amply in the description of the activities of the psychiatric social worker in the hospital and in the clinic. Mention has also been made that the psychiatric social worker, in addition to providing services to the patient and to his family, also serves as the co-ordinator of the hospital facilities on behalf of the patient. This latter function is not paralleled in the clinic. Both the clinic and the hospital worker, however, are engaged in mobilizing or creating those resources in the community which can be helpful to the continued or resumed functioning of the patient. This includes referral to other social agencies, referral to employment services, vocational-guidance resources, etc. This also includes alerting the community to the lack of resources, and the need for more resources for the care of the patient, such as foster care and rehabilitation facilities.

An additional function of the psychiatric social worker on behalf of the patient which has not been sufficiently stressed is the sharing by the psychiatric social worker with the other members of the team of the data on the patient's social functioning. This

will enable the other members of the team to carry out more effectively their respective treatment roles.

SIXTH PRESUPPOSITION

Psychiatric social work practice has developed new areas of activity.

In addition to group work and the specific community organization activities which were described, a number of recent developments deserve notice. Hospitals are experimenting with the use of volunteers, and psychiatric social workers often provide supervision and instruction in these experiments.

Teaching practitioners of related disciplines, particularly nurses and physicians, the meaning of the social factors in illness, as well as teaching of allied personnel such as attendants, is undertaken by psychiatric social workers. Increasingly, psychiatric social workers are appointed to the faculties of medical schools, where they participate in formal and informal teaching. Consultation is also a recently expanded function of psychiatric social workers who serve not only social agencies such as departments of public welfare, but also health departments, schools, courts, and personnel departments in industry.

The development of community organization for mental health also led to the use of psychiatric social work skills. The workers function either in order to stimulate citizen interest which will lead to the creation of mental-health facilities or infuse a mental health point of view into already existing facilities. It is interesting to note that increasingly the community organization function is seen as a legitimate and necessary portion of the state and federal mental health authorities.

Interest in research and the availability of research training through advanced study in schools of social work has also led to the participation of psychiatric social workers in research undertakings, either jointly with other members of the clinical team or alone.

A fairly controversial but increasingly important feature of psychiatric social work is the phenomenon of private practice. Private practice, which is carried on primarily in large urban centers, takes on two forms: (1) a more or less informal team arrangement with a psychiatrist, leading to mutual referral and consultation where the social worker carries on the traditional func-

tion of social work; (2) private practice carried on without a team relationship and the social worker taking on psychotherapeutic functions.

Not among the least-important trends in psychiatric social work are developments in professional education. Most schools of social work no longer distinguish the training of psychiatric social workers from the training of other social workers. This is to say that the course work is the same for all, especially as far as the courses on the methods of social casework, social group work, and community organization are concerned. The only differences occur in field instruction, which involves supervised practice by psychiatric social work students in a psychiatric setting. The learning in the field of the operations and functions of psychiatric agencies and of the role of the psychiatric social worker as a member of the team is buttressed in a number of schools of social work by classroom courses which analyze the specifics of psychiatric settings. This is educationally sound and in addition serves to reduce the lingering conviction that there is a qualitative difference between psychiatric social work and other forms of social work. Beyond the master's degree, which in social work education is the terminal degree for the majority of professional practitioners, a select number of schools of social work have developed programs of advanced study and training. These include, in many instances, training opportunities in psychiatric settings for the purpose of deepening or refining the skills of psychiatric social work. Many of these training opportunities are an outgrowth of mental health legislation that followed World War II and are financed from federal funds.

SEVENTH PRESUPPOSITION

Analysis of certain elements of psychiatric social work suggests the existence of a sociology of psychiatric social work.

An examination of the social role of psychiatric social work in the field of social work suggests that psychiatric social work has a number of characteristics which deserve analysis. The degree of professionalization, the social status of psychiatric social work, and psychiatric social work as a professional subculture, are considerations which have been suggested by Greenwood.¹³

¹³ Ernest Greenwood, *Toward a Sociology of Social Work*, Research De-

THE DEGREE OF PROFESSIONALIZATION

Like the other fields of social work, psychiatric social work is not fully professionalized. It lacks a monopoly of service which the community accepts and is not endowed with legal sanctions against malpractice. However, more than any other field of social work, psychiatric social work is rigidly controlled through the administration of membership requirements of the American Association of Psychiatric Social Workers. This organization stipulates complete professional social work training and experience in the practice of psychiatric social work as prerequisites for membership. Practically no clinic employs a psychiatric social worker who is not trained, and the hospitals for the mentally ill, and especially those which have been created since World War II under federal auspices, move in the same direction. The Berkman study¹⁴ shows that 64% of all workers in clinics and hospitals in 1950 had complete social work education, that 18% had some, and 18% had none. In the hospitals the breakdown is 45% with complete training, 24% with some, and 31% with none. In the clinics 85% have complete, 11% some, and only 4% no training. It may be said that even though comparative figures are not available, as measured by the criterion of status attached to membership in the American Association of Psychiatric Social Workers, psychiatric social work is professionalized to a higher degree than any other form of social work.

THE SOCIAL STATUS OF PSYCHIATRIC SOCIAL WORK

One of the ways by which social status can be measured is the examination of comparative incomes. A study by Maxine G. Stewart,¹⁵ based on figures of the Bureau of Labor Statistics, finds that in 1950 the average salary of social workers was \$2960.00 per annum. The Berkman study reveals a median salary based on figures for the same year of \$3750.00 for psychiatric social workers. The clinic group's median salary was \$3950.00 and the hospital group's median salary \$3450.00. The study also shows a strong positive correlation between education and salary.

partment, Welfare Council of Metropolitan Los Angeles. Special Report No. 37, 1953 (mimeo.).

¹⁴ Berkman, *op. cit.*, p. 28.

¹⁵ Maxine G. Stewart, "The Economic Status of Social Workers, 1950," *Social Work Journal*, XXXII (1951), 53-55.

Another status measure is the intraprofessional prestige of psychiatric social work as compared with other fields of social work. There is little doubt that the psychiatric social worker, and among this group the clinic worker, is within the profession accorded the pinnacle position of the hierarchy. In fact, schools and agencies show concern over the frequency with which prestige seems to motivate students to select psychiatric social work as their field of practice.

A third measure of status is suggested by the fact that psychiatric social workers predominate among the members of the profession who enter private practice. In a free-enterprise society such a step is more likely to be rewarded with prestige than is agency practice, which runs counter to the culture's expectation for the professional person.

The very fact that the adjective "psychiatric" is part of the professional designation of the psychiatric social worker helps in the creation of prestige, since psychiatric social work partakes of the esteem which is accorded to the psychiatrist.

It is interesting to note that status is high in psychiatric social work despite the fact that psychiatric social work, more than any other branch of social work, is a feminine profession. However, in analyzing the sex ratio of a profession or subprofession it is probably necessary to take into consideration not only the number but also the caliber of positions held by men and women respectively. There appears to be a trend toward predominance of males in the higher administrative, consultative, and supervisory positions. This seems particularly evident in the federal psychiatric social work program.

PSYCHIATRIC SOCIAL WORK AS A PROFESSIONAL SUBCULTURE

The question may be raised whether psychiatric social work has certain characteristics that cause members of the group to behave in ways which are different from those of other members of the social work profession.

One such characteristic is the fact that for many social workers the psychiatric social worker constitutes the ego ideal. Another characteristic is that the social setting in which the psychiatric social worker functions is one which typically brings him in close association with a high-status member of a high-status profession, the psychiatrist. This tends, as mentioned above, to

provide a certain amount of vicarious prestige to the psychiatric social worker, both in the eyes of the public and in the eyes of the other members of the social work profession who share overall cultural conceptions.

The fact that psychiatric social workers, like other social workers, practice in social settings where one of the criteria of success is effective collaboration with other members of the staff and members of other professions deserves attention and study. The nature of the bureaucratic structure of the social agency, which tends to minimize hierarchical and authoritative relationships, requires examination with special reference to psychiatric social work. The pattern of upward mobility in the psychiatric setting, where the prestige position of the administrator is only occasionally occupied by the psychiatric social worker in the clinic and practically never by the psychiatric social worker in the hospital, also requires analysis.

The attitudes of the community, which may be expected to be more positive toward the psychiatric social worker than toward other social workers, also would provide a basis for feeling superior on the part of the psychiatric social worker.

A relatively unexplored area of examination is the socio-economic background of psychiatric social workers. Are they more likely to come from the middle class than other social workers? Are they reference groups more likely to be associated with middle- and upper-class status?

What are the values of psychiatric social workers? Are they different from other social workers? Is the fact that most psychiatric social workers operate in urban centers and have, especially in the clinics, a middle- and upper-class clientele, responsible for their seeming lack of concern for social change and causes of social disorganization? Is this one of the reasons for the animosity felt toward them by their colleagues in public assistance, whose task it is to help individuals meet such basic human needs as food, shelter, and clothing?

Pending studies into these and other related areas it might be surmised, however, that psychiatric social workers come closer than any other social workers to having reached the earmark of professionalization and to possess the characteristics of a distinct subculture. An awareness of these factors is likely to help psychiatric social workers in the execution of their role vis-à-vis the collaborating professions and the community at large.

THIRTY-SIX

Toward a Social Psychology of Mental Health*

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I. SCOPE AND ORIENTATION

THE PURPOSE of this paper † is to examine what is known and what should be known about *the impact of community influences on the mental health of the individual*. In one form or another this vast subject, with its virtually unlimited ramifications, has occupied the minds of men for thousands of years. Political philosophers and political scientists in ancient and modern times have often justified the systems they advocate in terms of their impact on the mental well-being of citizens. Hippocrates, for example, in comparing democratic and monarchic forms of government, states that "institutions contribute a great deal to the

* From *Problems of Infancy and Childhood*, Milton J. E. Senn (ed.), Josiah Macy, Jr. Foundation, New York, 1950, 23 pp. Reprinted by permission of the author and the publisher. The plan for this paper was developed in conjunction with Dr. Stuart W. Cook; he contributed many of the ideas and formulations it contains. The author is also indebted to Dr. Brewster M. Smith and to Dr. Viola Bernard, who have gone over an earlier draft of this paper and criticized it in considerable detail. Many of their constructive suggestions are incorporated in the present text.

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formation of courageousness." In addition to a vast array of similar insights into the interaction between institutions and mental health which have become available through the observations of men who have followed Hippocrates, anthropologists and psychiatrists of this century have made a host of factual and theoretical contributions to the subject.

The very wealth of these contributions imposes the necessity to choose among them for presentation in this statement. The guiding principle for the selection was largely the wish to furnish information and guides for research which would be in accord with the broad purpose of the Midcentury White House Conference on Children and Youth "to consider how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and responsible citizenship, and what physical, economic and social conditions are deemed necessary to this development."

To be more specific, we are, then, looking for facts, concepts, and theories on the interaction between community influences and mental health which *can be applied* in the attempt to enhance the mental health of children and young people; this knowledge to be of a nature that it can be applied *widely to groups of individuals* rather than demand application to one person at a time.

In order to be applicable, the knowledge which we are seeking must be related to *situations where there is a genuine choice between alternatives*. If we should arrive at the result that living in the atomic age has unhealthy implications for personality formation, we would be better informed than previously, but since we obviously have no choice about living in the atomic age or at any other period, the application of such knowledge would not be possible. If we are to make constructive discoveries which can be applied, the analysis of the problem must be conducted so as to unearth alternatives possible within the atomic age.

To take another example: any knowledge we might acquire about the differential effect on mental health of, say, life in an urban or a rural setting would not be of the sort we are seeking in view of the fact that the division of labor which results in urban and rural life appears to be inevitable in our society. The community influences on which we wish to concentrate must, then, be of a kind which can be modified and redirected in the interest of the members of the community.

This emphasis on the pragmatic aspects of our task is deliberate

and pursued in full recognition of the fact that it is certainly not the only feasible approach to the subject. It must be understood as a limitation of the range and type of community influences with which we are concerned rather than as a lack of concern with theory. We have found, in the past, that the potential usefulness of thought need not detract from, and has on occasion added to, its scientific quality.

A further limitation is contained in this preliminary description of our task: it excludes concern with individual therapy. This, again, is a utilitarian decision. At the present cost of psychiatric treatment and in view of the relative scarcity of psychiatrists and the magnitude of the problem, the knowledge that psychotherapy can restore the mental health of young people contains, unfortunately, no promise that the mental health of a generation can be improved.

II. THE CONCEPT OF MENTAL HEALTH

Perhaps the greatest handicap for a systematic study of the social conditions conducive to mental health is the very elusiveness of this concept. As far as we could discover, there exists no psychologically meaningful and, from the point of view of research, operationally useful description of what is commonly understood to constitute mental health. Yet the establishment of some criteria by which the degree of mental health of an individual can be judged is essential if one wishes to identify social conditions conducive to the attainment of mental health. In an effort to choose such criteria we shall examine below five possibilities chosen either because of their familiarity or their apparent value, or both. The five are: the absence of mental disease, normality of behavior, adjustment to environment, unity of personality, and correct perception of reality.

THE ABSENCE OF MENTAL DISEASE

There is widespread agreement that the absence of mental disease is a necessary, though by no means sufficient, condition of mental health. However, even the definition of mental disease meets with considerable difficulties.

Anthropologists tell us about cultures in which what Western civilization would regard as symptoms of mental disease is gen-

erally accepted behavior. According to Ruth Benedict, the Kwakiutl Indians of British Columbia engage in behavior which would be called paranoid and megalomaniac in our culture. Their view of the world has similarities with what we regard as delusions of grandeur.¹

F. Alexander interprets the Buddhistic self-absorption of mystics in India, with its physical manifestation of rigidity and immobility, as an artificial schizophrenia of the catatonic type.² Now it is apparently true that the Buddhist can control the onset and end of his "symptoms," a feat which the schizophrenic person in our culture cannot, of course, perform. The example indicates that the similarity in symptoms must not be mistaken for an identical disturbance of functions. It also illustrates—and this is important here—that identical observable symptoms are regarded in one culture as achievement, while in another they are regarded as a severe debility. Examples could be multiplied to indicate that *the evaluation of behavior as sick, or normal, or extraordinary in a positive sense depends largely on accepted social conventions*. This differential evaluation of symptoms is not limited to cross-cultural comparisons. Within our society a farmers' community may well regard as symptoms of mental disorder the behavior of, say, an urban artists' colony. It follows, then, that mental disease is not to be defined in terms of isolated symptoms but rather in conjunction with the social norms and values of the community in which the symptoms are observed.

Even with this qualification, however, the absence of mental disease is not a very satisfactory indication of mental health. For the borderline between what is regarded as normal and as abnormal is dim and ill defined in all but the extreme cases. Neurotic and psychopathic personalities, for example, belong to that large border area to which the application of the label "mental disease" is not much more defensible than that of the label "mental health," unless we can discover more appropriate criteria for one or the other than are implied by the current usage of these terms.

In summary, then, it appears that an effort to arrive at a satisfactory definition of mental disease does not solve our problem

¹ Benedict, Ruth: *Patterns of Culture*. Boston and New York: Houghton Mifflin Co. (1934).

² Klineberg, Otto: *Social Psychology*. New York: Henry Holt and Co. (1945).

but rather adds others. It would seem, consequently, to be more fruitful to tackle the concept of mental health in its more positive connotation.

NORMALITY OF BEHAVIOR

Here, again, an amount that can hardly be overestimated has been learned from the cultural anthropologists, whose entire work can be regarded as variations on the theme of the plasticity of human nature and, accordingly, on the vast range of what can be regarded as normal. They have convincingly demonstrated the great variety of social norms and institutions invented by different cultures in different parts of the world and the fact that in different cultures different forms of behavior are regarded as normal.

It is generally accepted that normality covers two different concepts which can but need not—and as a rule do not—coincide; namely, normality as a statistical frequency concept and normality as a synonym for the elusive concept of mental health. (The lack of coincidence between the two concepts is most dramatically demonstrated in episodes of mass hysteria, for example, the response to the Invasion from Mars broadcasts, as described by Cantril.³ In so far as normality is used as a synonym for mental health, the problems of concept definition are, of course, identical. It remains to be seen what can be learned from the frequency concept. Here the practice of anthropologists concerned with the culture of nonindustrialized small tribes and those of social scientists concerned with the culture of this country are often opposed; the former do not, as a rule, apply the statistical normality concept, perhaps because the uniformities are so much more general in the small tribes with which they deal than in our society. However this may be, there are in our culture behavior distributions of very different types. With regard to many forms of behavior, the distribution of the population follows a normal curve; that is, the majority manifests a medium course, with about a quarter of either extreme of behavior. This is true, for instance, for many biological functions (height, weight, and so forth). This type of distribution is so frequently expected that it is actually taken as the basis for the standardization of all tests of psychological functions. However, there are many forms of behavior which do not follow the normal curve. An example is the

³ Cantril, H. (with the assistance of Hazel Gaudet and Herta Herzog): *The Invasion from Mars*. Princeton: Princeton University Press (1940).

knowledge of languages, where the overwhelming majority of the population speaks one and only a few two or more. Another is the voting behavior in this country, where only about half the population exercises its privileges to vote, while the other half does not vote. In this case voting would be as "normal" in the statistical sense as not voting. One may assume that these different types of distribution of behavior result, in part, from differential pressures to conformity.

If we are dealing with a distribution of behavior, such as is exemplified in the ability to speak one or more languages, the dividing line between what is normal and abnormal (in the statistical frequency sense) is obviously easier to draw than if we are dealing with a normal distribution curve. It may well be possible to distinguish cultures in terms of the tolerated range of behavior deviant from the statistical norm. In this country, which, according to its explicit creed stands in many respects for a variety of permissible behavior rather than for uniformity, the *criteria for mental health must be such that they do not automatically exclude everything but the average.*

ADJUSTMENT TO ENVIRONMENT

The concept of adjustment implies the establishment of a workable arrangement between personal needs and social conditions. We propose to regard the absence of any such arrangement (observed, for example, in many cases of mental disease) as a definite counterindication of mental health. In such cases individuals lack the ability to adapt themselves to the changing demands of a changing environment; they cannot adjust. While the inability to adjust is a counterindication of mental health, not every form of adjustment is a positive indication of mental health. There are also workable arrangements with the environment which we wish to exclude from a notion of mental health. A case in point is provided by the study of the impact of parental unemployment on children and young people. In a study of an Austrian village in which virtually the entire population was unemployed,⁴ children and young people had been compelled to adjust to the economic situation by a profound resignation and restriction of personal needs. These children had fewer and more humble wishes, life plans which anticipated failure ("When I grow up I want

⁴ Jahoda-Lazarsfeld, M., and H. Zeisl: *Die Arbeitslosen von Marienthal*. Hirzel: Leipzig (1932).

to be an Indian chief, but I am afraid it will be hard to find a job," a nine-year-old said), and restricted imagination when compared with children of employed families. Their "adjustment" is perhaps better described as a *passive acceptance of social conditions* to the detriment of their mental health. Under conditions of prolonged unemployment or in other situations where the external pressures are extreme, passive acceptance may be the only possible workable arrangement—which is only another way of saying that these conditions are inevitably detrimental to mental health.

Actually, one of the Marienthal youth did find another way: he rebelled against the restrictive features of an unemployed family, committed some minor thefts, and was placed by the juvenile court into a reformatory in which he was trained as an electrician. It is at least a moot question whether his rebellion was mentally not more healthy than the resignation of his contemporaries.

In the case of these young people, their ability to adjust to their environment resulted in a severe curtailment of personal needs. To be sure, they had found a workable arrangement with the conditions of life imposed on them: they had bowed to the dictatorship of circumstances. Such passive acceptance is by no means limited to extreme social conditions. Erich Fromm⁶ and David Riesman⁷ in their studies of political apathy, among others, have drawn attention to some areas in which passive acceptance threatens to become the rule rather than the exception.

A British study of young factory workers⁷ showed the same trend toward passive acceptance. Within a few weeks after these young factory girls had made the transition from school, where the main values were intelligence, industriousness, respect for the teacher and older people in general, to the factory, where intelligence was useless, hard work frowned upon by one's colleagues, and respect for age out of place, they had adopted completely the new set of norms.

To regard such forms of passive acceptance as a counterindication of mental health, notwithstanding the fact that it may be the type of behavior followed by a considerable majority, is ulti-

⁶ Fromm, E.: *Man for Himself*. New York: Rinehart (1947).

⁷ Riesman, D.: *The Lonely Crowd*, New Haven: Yale University Press (1951).

⁷ Jahoda, M.: "Some Socio-Psychological Problems of Factory Life," *Brit. J. Psychol.* (January, 1942).

mately based on social and moral values rather than on objective criteria. If one believes that everything which exists is right by virtue of its existence, then passive acceptance forms a valid criterion for mental health. We do not believe this. Furthermore, it would appear that such a static view of society is untenable in our constantly changing world. Circumstances are better or worse, and are judged and experienced by most people in these terms. Passive acceptance denies or ignores these judgments.

In contrast to passive acceptance there is another form of active adjustment which is indeed linked to our as yet vague notion of mental health. It is perhaps best described as a mastery of environment. An environment which makes it possible to implement Henry V's royal statement, "We are the makers of manners," is by this criterion conducive to mental health.

Active mastery of environment presupposes a deliberate choice of what one does and what one does not conform to and consists of deliberate modifications of environmental conditions. It aims at creating an environment with which one can feel at home. In a society in which regimentation prevails, active adjustment will hardly be possible; in a society where overt regimentation is replaced by the invisible compulsions of conformity pressures, active adjustment will be equally rare. Only where there exists social recognition of alternative forms of behavior is there a chance for the average individual to master his surroundings and attain mental health.

There are, however, periods of life in which active adjustment through a modification of the environment is less feasible than at other periods. Childhood and even adolescence limit the scope of possible modifications of one's surroundings.

Adolescents in our society are inevitably subject to specific discomforts of civilization. At a time when young people are physically mature enough to lead the life of adults, certainly in the economic and the sexual spheres, our civilization interposes a period denying to the adolescent economic and sexual adulthood and providing him, in their stead, with a chance to experiment without having to face the major responsibilities of complete independence.

Adolescence, a period of protected growth, is a time when independence from the parental family is gradually achieved; a time when through rebellion, conflicts, doubts, or through some smoother form of transition, young people acquire a wide range

of experiences, undergo the trials and errors of forming personal relationships, develop new group loyalties, change their minds and interests, and commit the creative and destructive errors of youth.⁸

If this is a correct description of the function of adolescence, passive acceptance of environmental demands can still stand as a counterindication of mental health. The criterion of active mastery of environment needs some modification in view of the dependence of adolescents which makes it unlikely that they can achieve it in all areas. Here it is the *attempts to modify conditions* in areas where the adolescent is inevitably dependent and the planning for more independent action in the future which should be regarded as symptoms of mental health. For the fully developed adult personality, anticipation and planning without realistic modifications would probably indicate a lesser degree of mental health. However, it should be kept in mind that even in the life of the adolescent there are many areas in which he has freedom of choice and that in these areas he has opportunities for active adjustments of the sort we have discussed.

UNITY OF PERSONALITY

Another possible criterion which has much to recommend itself is the concept of a *unity of personality*, which, though perhaps not formulated in these terms, underlies much of psychoanalytic thought and, it would appear, is the goal of psychoanalytic therapy.

On the basis of evidence derived from psychoanalysis, Heinz Hartmann speaks of "a general trend of human development, the trend towards a growing independence from the immediate impact of present stimuli, the independence from the *hic et nunc*;" and, somewhat later, of the "growing independence from the outside world, in so far as a process of inner regulation replaces the reactions and actions due to fear of the social environment (social anxiety)."⁹ Other nonpsychoanalytic authors, in describing similar processes, speak of "self-consistency" or "self-realization."

The proposition being stated here is that the person who acts according to a consistent inner regulation and is relatively free

⁸ Research Center for Human Relations: *College Life: A Research Plan*, an unpublished memorandum.

⁹ Hartmann, H.: "On Rational and Irrational Action," *Psychoanalysis and the Social Sciences*, 1 (1947).

from conflicts among the three constituent parts of personality: id, ego, and superego—in other words an integrated personality—should be regarded as a mentally healthy person. It is perhaps not quite superfluous to add that this does not imply freedom from conflicts with his environment.

Of course it may be true to say that the catatonic patient, for all we know about him, manifests a very high degree of unity of personality; he certainly appears to be entirely self-regulated. The example demonstrates vividly that no single criterion for mental health will ever suffice. If unity of personality is taken as a criterion not alone but in conjunction with active adjustment, the catatonic patient is, of course, immediately ruled out. Indeed, it is the unity of personality, the maintenance of the inner core, which makes active adjustment possible.

CORRECT PERCEPTION OF REALITY

There is at points in the preceding discussion a hint that the correct perception of reality (including, of course, the self) may serve as another useful criterion of mental health. Unless active adjustment involving the modification of the environment is to rely on hit-or-miss methods, it must be based on correct perception of the environment. If the unity of personality is to persist over a period of time in the face of the inevitable conflicts of life, it must be based on correct self-perception.

The difficulty in the use of this criterion arises over the word "correct." Especially in the perception of more complex phenomena, such as one's own status concern or a country's war-mindedness, it is indeed hard to establish what is correct and what is incorrect perception. A judgment by the majority is not necessarily more correct than one by a single individual. However, there are certain phenomena with respect to which the correctness of perception can be checked objectively. In a biracial housing project,¹⁰ one-half Negro and one-half white tenants, many of the white tenants, who were prejudiced against Negroes, consistently overestimated the proportion of Negroes in the project; their perception was, apparently, determined by their fear of being outnumbered. In this sense their prejudices impaired their mental health.

Where the correctness of perception can be ascertained, as in

¹⁰ Merton, R. K., P. S. West, and M. Jahoda: *Explorations in the Social Psychology of Public Housing*. New York: Harper and Brothers.

this case, it provides indeed a useful and psychologically meaningful criterion of mental health. Where the objective yardstick is missing, however, the use of the criterion will present difficulties. To establish that the same occurrence can be perceived differently by different people does not yet indicate, of course, whose perception corresponds with reality.

A MULTIPLE CRITERION

As will doubtless be clear from the discussions of the individual criteria, we suggest tentatively that a combination of three criteria be used for determining the mental health of an individual: (a) active adjustment or attempts at mastery of his environment as distinct both from his inability to adjust and from his indiscriminate adjustment through passive acceptance of environmental conditions; (b) unity of his personality, the maintenance of a stable, internal integration which remains intact notwithstanding the flexibility of behavior which derives from active adjustment; and (c) ability to perceive correctly the world and himself.

We propose that whether or not a given environment may be considered conducive to mental health depends upon the barriers it erects against the realization of the maximum value for each of these three criteria. It is easy to imagine social conditions which favor one or two but exclude others. Heroic efforts in fighting for a lost cause, for example, obviously exclude correct perception which, in self-defense, is replaced by illusions. Under conditions of unemployment active adjustment may be impossible, as we have seen. Under the conditions of a polysegmented society with many incompatible values and norms, the unity of personality may be abandoned for the sake of opportunistic adjustment in terms of correct perception. In cases such as these, where environmental reality blocks the achievement of full mental health in the sense of maximal realization of all three criteria, we may still ask what is optimum mental health for a given set of circumstances. Granted, for example, that reality makes impossible the achievement of certain personal needs (and is thus detrimental to the realization of full mental health), there will still be some optimum balance of the three criteria of mental health and evaluative comparisons with this optimum may be made.

III. SOME CONCEPTS AND THEORIES RELEVANT TO THE STUDY OF MENTAL HEALTH

With these tentative criteria for mental health in mind, we may now return to the question of the impact of community influences on mental health. It will be helpful here to turn to established psychological theories and concepts which, though not explicitly formulated in relation to the study of community influences on mental health, may, nevertheless, guide it into fruitful channels. We shall briefly examine the psychodynamic theory of personality formation, field theory, modal personality and culture patterns, and the concepts of status and role.

PSYCHODYNAMIC THEORY OF PERSONALITY FORMATION

Whether we agree with Ignatius of Loyola that the personality is set by the age of seven, or with early psychoanalytic theory that it is set at an even earlier age, or are in accord with current psychoanalytic thinking which attributes to the latency period up to the age of ten or so a function in personality formation, there appears to be a consensus of opinion as to the decisive influence of early experiences. Granted this, there remains the question of how the social norms to which the individual is exposed *at a later stage* can affect his personality to an extent that it changes the degree of his mental health.

Obviously many events, decisive for personality formation, have occurred before the child is exposed to social conditions other than those inherent in his family. At the Oedipal stage the crucial process of identification with the parents gets under way, and the success or failure of this process is of lasting influence on the development of the superego and the child's capacity to identify in later life with groups and individuals. Even before this stage, in the first year of life, the child has learned to achieve a relation to objects through the gradual constitution of the ego as distinct from the surrounding universe, that is, his mother.

Psychoanalytic theory maintains that serious personality disturbances acquired at any of these crucial stages are irrevocable unless psychoanalytically treated and that environmental change afterward has little remedial value. René Spitz and Catherine Wolf, for example, have presented evidence showing the rapid

mental and emotional deterioration of infants separated for some length of time from their mothers or mother substitutes.¹¹

Psychoanalysts would agree, however, that even if everything went well, relatively speaking, up to the age of the latency period, subsequent social factors may still have a severely disturbing impact. Indeed, the concept of regression exemplifies such a personality change as the result of particular environmental stress and strain in later life.

On the other hand, psychoanalytic theory has been less explicit on other changes which occur in later life under the impact of environmental factors. There can be little doubt that such changes do actually occur under extreme conditions. Bettelheim's analysis of the behavior of inmates of concentration camps, for example, provides evidence in this direction. It is quite possible that what happens under extreme conditions can also occur as the result of a prolonged impact of less extreme pressures.

FIELD THEORY

The question can here be legitimately raised as to whether we are talking in the preceding discussion about personality changes or about different behavior of one and the same personality under different external conditions. According to Kurt Lewin's field-theoretical approach,¹² behavior is always a function both of personality and of environment, a formulation which encompasses the facts regarding changes in later life and is complementary to, rather than inconsistent with, psychoanalytic theory. It would seem, then, that the answer depends on whether or not the behavioral change persists when the original environmental conditions are restored. All through life environment acts as an agency mobilizing selectively different facets of the personality. There are in every human being, even after the age of ten, many more latent possibilities than meet the eye. It is the pressure of the external world that can alternately favor or reject some personality traits, for shorter or longer periods.

In the light of the psychodynamic and field theories, we may

¹¹ Spitz, Rene: "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," *Study of the Child* (1945).

¹² Lewin, Kurt: *The Principles of Topological Psychology*, New York and London: McGraw-Hill (1936). *Resolving Social Conflicts*, New York: Harper & Bros. (1948).

expect that personality and mental health can be modified by community influences in two ways: (a) through the environmental impact on parents which they will transmit to their children from birth onward and (b) through behavior changes demanded by environmental pressures which may establish permanent patterns. It remains to be seen whether some broad aspects of the environment can be specified which tend to influence the mental health of large numbers of people, notwithstanding the fact that the same environment will have a different meaning for different personalities.

MODAL PERSONALITY AND CULTURE PATTERNS

One of the most important applications of psychoanalytic theory to the study of environmental impact on personality comes from anthropology through the cooperative effort of Kardiner and Linton.¹³ Kardiner has advanced the concept of *basic personality* to describe a phenomenon similar to that referred to by the more widely and vaguely used term "national character"; he has based the concept upon a psychoanalytic interpretation of personality. Linton defined basic personality as a configuration of several elements resting upon the following postulates: early experiences have a lasting effect upon personality; similar experiences will tend to produce similar personality configurations; child rearing is culturally patterned and within one society similar in all families although not identical; child rearing differs from one culture to the next. From this he deduces that the members of a given society have many early experiences in common, hence many personality elements in common. It follows that personality norms will differ in different societies.

The crucial aspect of this concept is the emphasis on differences in child rearing practices (differences which may be functionally related to differences in other spheres as, for example, economic organization or sex mores) and their relation to the emergence of different personalities.

Kardiner and Linton's contribution derives its importance from having produced a model of thought and demonstrated the process of concept formation in this difficult area. But the very conception of basic personality, with its emphasis on child rearing, makes

¹³ Kardiner, A.: *Psychological Frontiers of Society*. New York: Columbia University Press (1945). Preface by R. Linton.

its application to contemporary American society difficult. First of all, the question arises whether in the United States we are dealing with one or with many different types of basic personality. In view of the wide range of tolerated deviations in child rearing practices, one is led to assume that more than one basic personality must be formed in this country.

Such evidence as exists on differences in child rearing practices in American society adds to the difficulty of applying Kardiner's concept. Some empirical investigations have, for example, demonstrated considerable and consistent differences in the child rearing practices of the American middle class and the American working class, and also among various ethnic subgroups.¹⁴ Kardiner has demonstrated, especially in his interpretation of the Tanala culture, how the entire structure of society—his "rational" and "projective systems"—reinforces and is reinforced by, child rearing practices. While there is not much systematic evidence on the point, it would appear that the American working class and middle class have largely overlapping and identical rational and projective systems (such as the economic organization of the country, or religion). Whether or not the two classes should theoretically be expected to produce different basic personalities is uncertain; whether or not they have different basic personalities has, as far as we know, not been investigated.

To sum up: the concept of basic personality seems to be more applicable to small uniform and self-contained cultures than to American society. If and when its usefulness for describing the impact of American subcultures upon personality formation (and perhaps mental health) can be established, modifications in sub-cultural characteristics can then be attempted by way of public education about child rearing. Since this is an effort which is rightly proceeding without awaiting the results of further research, it should be stated that in keeping with Kardiner's work and with psychodynamic theory in general, the term "child rearing practices" must not be narrowly interpreted. For it is, after all, not a gesture but the meaning of a gesture in its emotional context which affects the formation of child personality. The most literal obedience to proper weaning procedures will not prevent the development of insecurity and anxiety if the mother's over-all attitude toward the child is rejecting.

¹⁴ Orlansky, H.: "Infant Care and Personality," *Psychol. Bull.*, 46, 1 (January, 1949).

STATUS AND ROLE

The concepts of role and status, and their relation to personality—both acquiring increasing prominence in current socio-psychological thinking—are perhaps more relevant to our problem because their existence has been established beyond doubt in all cultures. According to Linton, even the simplest societies know of at least five different kinds of status: age-sex, occupational, rank and prestige in some hierarchical relation, family or clan, and association group. Status may be either “ascribed,” as is the case with the status of the child or minority-group member, or “achieved,” as is the case with the status of businessman or president of an organization. A role is, in Linton’s words, “the sum total of the culture patterns associated with a particular status. It thus includes the attitudes, values, and behavior ascribed by the society to any and all persons occupying this status. . . . A role is the dynamic aspect of a status.”¹⁵

The notions of status and role lead us one step nearer to the understanding of our task: the impact of the environment on the personality of an individual will be transmitted by way of the status he is ascribed or which he achieves, and the roles that go with such a status. As Newcomb points out in some detail, the various roles one plays in society can be compatible or incompatible with each other. Even where they are compatible, they can be culturally defined in a manner which strains all resources of a personality to an extent that is hardly bearable. One has only to remember the roles assigned to a Jew under the Nazi regime to realize the close link between the definition of roles and the mental well-being of an individual in terms of our criteria of mental health. Where the roles are incompatible, the strain on mental health, especially with respect to the unity of personality criterion, will be considerable.

IV. IN SEARCH FOR ENVIRONMENTAL FACTORS
INFLUENCING MENTAL HEALTH

After this sketchy review of our conceptual tools, one fact is established beyond doubt: we do not yet possess a theoretical system, nor even a logically consistent framework, with which to

¹⁵ Newcomb, Theodore: *Social Psychology*. New York: The Dryden Press (1950).

tackle the task of enhancing mental health through the modification of environment. By way of remedy, we would argue that the formulation of theory proceeds best when it is closely linked to empirical research. If we, therefore, now turn to the directions research might take, it is done in the belief that systematic study will, in the end, be the most economical way toward the development of a theory which can safely be applied to guide community change to the benefit of mental health.

ALTERNATIVE APPROACHES

One could approach the study of community influence on mental health by selecting individuals manifesting either a high or a low degree of mental health (as defined, for example, in terms of our suggested criteria) and investigating the set of social influences to which they had been exposed throughout their lives. This approach has, undoubtedly, much to recommend it. In a way all forms of psychotherapy present a contribution to the understanding of mental health along these lines. In view of the earlier definition of our task, however, it is not for the present purpose a very economical approach. The chances are that research which sets out to account for the difference between mentally healthy and unhealthy individuals will be led into a study of medical, economic, psychodynamic factors, and the like, as well as of community influences.

A second approach seems to be more directly related to our task. It consists in the study of the mental health of individuals in small, well-defined groups (units, communities). In so far as one is dealing with groups which have distinctive characteristics, these characteristics are kept constant as an influence in the mental health of all members. To the extent that the mental health of individuals in groups with one set of characteristics differs from that of individuals in other groups with different characteristics, we may be in a position to attribute the differences in mental health to the differences between groups. To be sure, one of the basic tenets of the concept of interaction between environment and the individual is that the same situation will be experienced differently by different persons. Nevertheless, if we can describe the common external reality with some objectivity, this may permit the establishment of some regularities in the impact of environmental factors.

THE COMPARABILITY OF SOCIAL UNITS

Having thus identified small communities as the locale on which such studies should most profitably concentrate, one might assume that the considerable number of community studies which have been conducted in this country and abroad could be regarded as a first step in research on community influences on mental health. But this, unfortunately, is not the case. The main difficulties confronting the use of available community studies for our purposes are that these studies are largely descriptive in sociological rather than in sociopsychological dimensions, and that even in the sociological dimensions *they are not comparable to one another*. From published material it is impossible to decide whether living in, say, *Middletown*¹⁶ or living in *Black Metropolis*¹⁷ affects people in any specific way for better or worse because the concepts and dimensions used in these and other community studies are not defined on a comparable basis. Even where the major spheres of human life are treated according to the *Middletown* model (getting a living, making a home, training the young, leisure, play, art, religion, community activities) in different studies, these broad categories do not help much in revealing psychologically meaningful differences or similarities in community influences on the individual.

The establishment of psychologically meaningful attributes of community life is in itself a major research task. Some beginning in this direction has been made in industrial psychology. This has been perhaps most impressively demonstrated in Elton Mayo's wartime studies of absenteeism in three different factories, where the pattern of relations between foremen and workers was regarded as a crucial sociological variable with psychological meaning.¹⁸ Other attempts in this direction undoubtedly exist, but much more will have to be done to establish comparable patterns of community life whose psychological relevance can be demonstrated.

There are, however, a set of conditions in community life whose

¹⁶ Lynd, R., and H. Lynd: *Middletown*. New York: Harcourt Brace & Co.

¹⁷ Cayton, H. R., and St. Clair Drake: *Black Metropolis*. New York: Harcourt Brace (1945).

¹⁸ Mayo, Elton: *Social Problems of an Industrial Civilization*. Boston: Division of Research, Graduate School of Business Administration, Harvard University (1945).

damaging effects need not be demonstrated through research because there is already in our culture an almost unanimous acceptance of the fact that they are detrimental to the individual. The conditions referred to are: hunger, bad housing, lack of medical care, unemployment, low wages, and so forth. There is much evidence on the detrimental effect of these factors on the physical and mental well-being of people.¹⁹ While all available social energy is needed to eliminate these conditions, considerations of research strategy suggest that new inquiries should not go out to prove what is already known. On the other hand, however, no community study can neglect to take these basic conditions of human life into account as essential background information.

SOME PROPOSITIONS FOR RESEARCH

The following propositions are only loosely connected with each other, since (as stated earlier) there exists no comprehensive sociopsychological theory of mental health in terms of which they can be interrelated. The only unifying link was provided by the search for community attributes which could be expected to have some bearing on one or more of the tentatively established criteria for mental health, and which occurred in a variety of social units such as villages, factories, colleges, army camps, housing projects, and so forth.

L. S. Cottrell, Jr., has developed a set of propositions about age and sex roles which are of considerable interest in relation to our problem. By way of example, here are two of his propositions: "The degree of adjustment to roles which our society assigns to its age-sex categories varies directly with the clarity with which such roles are defined," and, "The degree of adjustment to a future role varies directly with the degree of clarity with which the future role is defined."²⁰

¹⁹ Bettelheim, B.: "Individual and Mass Behavior in Extreme Situations," *J. Abnormal and Social Psych.*, 38 (1943). Faris, Robert E., and H. W. Dunham: *Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses*. Chicago: University of Chicago Press (1939). Rowntree, B. S.: *Poverty and Progress*. London: Longmans, Green & Co. (1941). Titmuss, R.: *Birth, Poverty and Wealth*. London: Hamish Hamilton (1944). Cayton and Drake, *op. cit.*

²⁰ Cottrell, Jr., L. S.: "The Adjustment of the Individual to His Age and Sex Roles," *Readings in Social Psychology*. New York: Henry Holt and Co. (1947). Orlansky, H., *op. cit.*

It should be noted that clarity here refers not to a reasoning process in individuals but rather to the institutions and values in society. Some roles in our society are notoriously ill defined, as, for instance, the role of aged parents in the life of their adult children, the role of the unmarried adult, the role of the intellectually trained woman, and so forth. It would be feasible and of considerable importance to apply Cottrell's propositions to these ill defined roles in comparative community studies.

It will be noted that Cottrell does not distinguish in his propositions between passive acceptance and active adjustment. It would appear that either notion could form the basis for a plausible hypothesis, though they are markedly different from one another. In addition, these hypotheses are plausible only when roles are defined so as to be compatible with other roles. No degree of clarity in the definition of the role of a Negro, when this definition implies his inferiority to white citizens, will help him to adjust if he also aspires to the role of a citizen with equal rights.

If, with these qualifications, studies are undertaken which demonstrate the impact on mental health of the clarity with which roles are defined, the implementation of the result through preventive measures will by no means be easy. It will most likely involve a change in role definition, a process about which there is little experience.

Another set of propositions can be developed around the notion of socially recognized individual achievements. If an educational institution like a college, for instance, is organized in such a manner that only the brightest students or only the very good-looking students are rewarded by community recognition, all others will be compelled to strive for the impossible with inevitable frustration and restrictions on personality. If a single type of behavior and achievement is rewarded, the pressure for conformity, that is, passive acceptance, may be dangerously great. This proposition postulates a recognition of the multivalue and multipersonality-type structure of contemporary life. David Riesman, who is continuously concerned with the power of the individual to resist conformity pressures, says in his article, *A Philosophy for "Minority" Living*: "The 'nerve of failure' is the courage to face aloneness and the possibility of defeat in one's personal life or one's work without being morally destroyed. It is, in a larger sense, simply the nerve to be oneself when that self is not approved by

the dominant ethics of a society." ²¹ This admirable ethical principle raises the question as to the factors which contribute to the development of such strength of personality. It may well be that prolonged exposure to a group which recognizes a variety of possible achievements is conducive to such development.

It appears that for Riesman the unity of personality is of much greater importance than active adjustment. While he does not say so explicitly, the resistance against pressures which he advocates presupposes, of course, correct perception of the self and its incompatibility with a given social environment.

The crucial test for the strength of mental health occurs as a person is transposed from one environment to the other when habitual patterns of behavior are challenged and interiorized values of the former environment are contradicted by the socially approved values in the new environment. The intellectual who is drafted into the army, the Sister Carrie who comes from the small isolated village into a metropolitan center, the immigrant from Europe, all are familiar with the strain inherent in such a change of environment. Actually, the experience of the British factory girls mentioned before was of the same nature, though in contrast to the other examples they did not expect to enter a new culture when they went from school to factory. This suggests another set of hypotheses: the correct perception of reality will increase through frequent changes of environment; this will at the same time, however, be conducive to passive acceptance unless the original "home" environment has enhanced the integration of the personality.

At the same time it suggests propositions about the original "home" environment (family, community, school, camp, college, place of work) which bear on the question as to when a protective environment becomes overprotective, that is, detrimental to mental health. The greater the chance to practice active adjustment and to reject passive acceptance at an early stage, the less is the likelihood that environmental changes will prove to be danger points. In the light of this hypothesis, the attempt to spare children and young people the experience and the perception of conflict and irreconcilable value differences is probably an obstacle to the development of mental health.

²¹ Riesman, D.: "A Philosophy for 'Minority' Living, New York," *Commentary*, 6, 5 (November, 1948).

These arguments are related to another set of propositions concerned with membership in voluntary groups. If a community is organized so as to favor mutually exclusive voluntary group memberships, the dependency of the individual on the one group to which he belongs will be dangerously great. In our multirole society, people need the chance to compensate for frustration and dissatisfaction in one group by more positive experiences in others. One-group membership resembles, in some respects, the over-protective environment discussed above. Examples of the disastrous effect linked with membership in one exclusive all-embracing group are provided by those who, for one reason or another, attempt to leave such a group (Communist party, certain religious groups, juvenile gangs, and so forth). When an individual belongs to other groups which put a less exclusive claim on his loyalty so that his identity as a person will not be threatened when he leaves one group, membership will enhance mental health. Groups which are organized to achieve a specific goal or purpose provide an opportunity for active adjustment.

These are but a few examples of possible research in this area. The scope of study appears to be as great as the need for it. If the research implementation of these propositions appears difficult, their application on a widespread basis will be even more difficult. But there is no other way than to try.

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Mental Hygiene and the Class Structure

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MENTAL hygiene constitutes for the sociologist a twofold interest, first as a social movement and second as an applied science (drawing upon several pure sciences of which sociology is one). Both sides of this interest fit with our present subject—the relation of mental hygiene to the vertical dimension of society—because any phenomenon which is at once a social movement and an applied human science cannot escape on two counts having some connection, however obscure it may seem, with the invidious, discriminatory aspect of social life.

We should like to define mental hygiene in terms of its chief aim, but the general goal as usually stated—improvement of mental health in the community, promotion of personal efficiency, or provision for personality expression and happiness—is ambiguous. It is difficult to determine whether mental hygiene practises are really conducive to such a goal, or whether the practises of any well-intentioned movement are not equally conducive to it. Our conception of mental hygiene, then, will embrace simply the movement and the point of view called by that name. The diffuseness of its main goal and the proliferation of subsidiary ends¹ will be viewed as symptomatic of its social role and function.

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¹ "The ultimate in mental hygiene means mental poise, calm judgment, and an understanding of leadership and fellowship—in other words, cooperation, with an attitude that tempers justice with mercy and humility."—Dr. M. J. Rosenau, "Mental Hygiene and Public Health," *Mental Hygiene*, xix (Jan. 1935): 9. Bromberg attributes to a prominent spokesman of the movement the following statement: "Mental hygiene . . . presents many wider aspects.

Now let us turn briefly to the vertical dimension in society. Its essence is the relative inferiority and superiority of persons in one another's eyes. It is manifest on the one hand in a *crystallized hierarchy* of positions (offices and statuses) which is supported by a correlative system of sentiments and a constraining set of legal and moral sanctions; and on the other hand in *interpersonal relations* where (in rough accord with the crystallized attitudes) every act, word and thought of the person is unremittingly subjected to the praising and condemning scrutiny of others. The vertical dimension is thus not limited to the wider or smaller circles; it is coextensive with the social.

Persons occupying similar positions in the hierarchy constitute a social class, in most cases a statistical rather than a real group. Class implies the division of persons into broad strata according to their final score in the summation of estimable tallies—the precipitate of all the countless criteria of invidious distinction. The strata may be so organized with reference to one another that movement up or down the scale is facilitated or blocked. The first type we call a system of mobile classes, the second a system of immobile castes. Each type possesses its appropriate world philosophy common to its members, absolutistic in expression, and conceived as an order of justice. Its principles penetrate to every

Industrial unrest to a large degree means bad mental hygiene, and is to be corrected by good mental hygiene. The various antisocial attitudes that lead to crime are problems for the mental hygienist. Dependency, insofar as it is social parasitism not due to mental or physical defect, belongs to mental hygiene. But mental hygiene has a message also for those who consider themselves quite normal, for, by its aims, the man who is fifty per cent efficient can make himself seventy per cent efficient. . . .”—W. Bromberg, *The Mind of Man*, New York, 1937, p. 217. So many similar statements can be found in mental hygiene texts, articles, and credos, that these quotations are typical.

Mental hygiene thus possesses a characteristic that is essential to any social movement—namely, that its proponents regard it as a panacea. Since mental health is obviously connected with the social environment, to promote such health is to treat not only particular minds but also the customs and institutions in which the minds function. To cure so much is to cure all.

A sane way to discuss mental hygiene is to assume that the purpose of mental hygiene is the prevention of positive mental disorder, and that it is therefore a branch of the public health movement, which intends not so much to make everybody bouncingly robust as to prevent the onset and spread of definite diseases. But since mental hygienists dub this limited goal as old fashioned, our realistic treatment cannot make the assumption.

phase and aspect of life, taking hold of the person in the dynamic maze of communicative, especially inter-personal and primary, contacts.

Our interest lies in our own mobile class system and its accompanying world philosophy. The latter, which may conveniently be called the Protestant ethic, and which receives its severest expression in Puritanism, is: (1) *Democratic* in the sense of favoring equal opportunity to rise socially by merit rather than by birth. (2) *Worldly* in emphasizing earthly values such as the pursuit of a calling, accumulation of wealth, and achievement of status. (3) But at the same time *ascetic* in stressing physical abstinence and stern sobriety, thrift, industry, and prudence. (4) *Individualistic* in placing responsibility upon the individual himself for his economic, political, and religious destiny, and in stressing personal ambition, self-reliance, private enterprise, and entrepreneurial ability.² (5) *Rationalistic* and *empirical* in assuming a world order discoverable through sensory observation of nature.³ (6) *Utilitarian* in pursuing practical ends with the best available means, and conceiving human welfare in secularized terms as attainable by human knowledge and action.

It can be demonstrated, we think, that this ethic is functionally related to an open-class society. Not only are the two historically connected, but it seems that an open-class society could scarcely work without such a philosophy.⁴

² The individualistic and worldly-ascetic qualities were delineated by Max Weber. See his *General Economic History*, trans. by F. H. Knight, Part IV, and *The Protestant Ethic and the Spirit of Capitalism*, trans. by Talcott Parsons, London, 1936.

³ R. K. Merton, "Puritanism, Pietism, and Science," *Sociological Review*, xxviii (Jan. 1936): 1-30. Max Weber, *op. cit.*, also points out the rationalistic character of Protestantism, as does W. Sombart in his *Quintessence of Capitalism*, trans. by M. Epstein, London, 1915, in his article on "Capitalism" in *Ency. Soc. Sciences*, 1930, and in his *Jews and Modern Capitalism*, London, 1913. Sombart, in the article cited, sums up the capitalist spirit in the concepts: acquisition, competition, and rationality. Following this lead we could regard capitalism as the competition for social status in terms of the acquisition of goods by rational manipulative processes.

⁴ The Protestant ethic was perhaps most characteristic of early capitalism, and it has doubtless fallen into some desuetude with subsequent social changes, but it still tends to form the unconscious premises of our thinking about conduct, even when in practice we do not follow its precepts. Veblen was particularly impressed with the archaic character of our present 18th century moral philosophy. (See his *Vested Interests and the Common Man*,

But what has this Protestant ethic, plus the underlying system of mobile classes, to do with mental hygiene? Our discussion of this point, suggestive rather than conclusive, will embrace the following propositions: first, that mental hygiene, being a social movement and a source of advice concerning personal conduct, has inevitably taken over the Protestant ethic inherent in our society, not simply as the basis for conscious preachment but also as the unconscious system of premises upon which its "scientific" analysis and its conception of mental health itself are based. Second, that this unconscious incorporation of the open-class ethic has made mental hygiene doubly susceptible to the psychologistic approach to human conduct, though the latter has represented, in part, a contradictory feature. Third, that the unconscious assumption of the dominant ethic, together with the psychologistic interpretation, has served to obscure the social determinants of mental disease, and especially the effects of invidious or emulative relationships. And finally, that mental hygiene will probably fail as a preventive movement because it cannot overcome its defects, the free analysis and manipulation of invidious social elements never being permitted in an integrated society.

The relation between mental hygiene and the open-class ethic is an unconscious one. Tacitly the textbooks for teachers and practitioners of the subject assume the existence of a mobile class structure and teach by implication the congruent moral norms. Frequently they interpret these norms as somehow given in the individual, and in the last analysis always define mental health itself in terms of them.⁵

N. Y., 1920). The Protestant ethic is still the living message of our departed moral authorities—Jefferson, Franklin, Lincoln, and Emerson—and is woven into poetry, song, and precept.

⁵ Our generalizations are based upon a systematic study of selected literature in the field, chosen from a list sent out by the National Committee for Mental Hygiene, Inc. In addition, a few other standard works were read with a view to sampling. All told, thirteen volumes were gone through, with the aid of a fixed questionnaire designed to discover certain things about each book. The books systematically perused are as follows: V. V. Anderson, *Psychiatry in Education*, N. Y., 1932; W. J. Burnham, *The Wholesome Personality*, N. Y., 1932; E. R. Groves and P. Blanchard, *Introduction to Mental Hygiene*, N. Y., 1930; Howard and Patry, *Mental Health*, N. Y., 1935; D. W. La Rue, *Mental Hygiene*, N. Y., 1927; J. J. B. Morgan, *Keeping a Sound Mind*, N. Y., 1934; W. V. Richmond, *Personality: Its Study and Hygiene*, N. Y., 1937; L. F. Shaffer, *The Psychology of Adjustment*, Boston,

Vertical mobility, for example, is taken for granted, and social advancement accepted as a natural goal. Democracy, in the form of equal opportunity to advance, is regarded as desirable. Lack of ambition is felt to represent a definite symptom of maladjustment, to be eliminated if possible. The normal person is considered to be one who chooses a calling and tries to distinguish himself in it, while the mentally sick person is one who needs occupational therapy.⁶

Likewise *competition* is assumed, life being regarded as a battle or a game in which victory goes to him who uses wit and strength to best advantage.⁷ Since the morality of the competitive system requires that we not violate the rules of the game, and that we not

1936; G. S. Stevenson and G. Smith, *Child Guidance Clinics*, N. Y., 1934; D. A. Thom, *Everyday Problems of the Everyday Child*, N. Y., 1928; J. E. W. Wallin, *Personality Maladjustments and Mental Hygiene*, N. Y., 1935; F. L. Wells, *Mental Adjustments*, N. Y., 1917; C. B. Zachry, *Personality Adjustments of School Children*, N. Y., 1929. Other literature, especially recent contributions in psychiatry dealing with the relation of mental disorder to social phenomena, was of course read.

⁶ Burnham, p. 522: "The democratic ideal in its higher form is based, not on an abstract myth of human equality, made concrete in an equal share of human necessities and social privileges, but based rather on the psychological fact of profound individual differences." "The ideal democratic group today is one where each member of the group has the opportunity to become superior in something according to his special ability."

Howard and Patry consider mobility on the whole a desirable condition, since it offers a goal for effort. But they criticize the mad scramble for money and "material" things. In other words, they condemn some of the particular goals of vertical movement, but they do not condemn (or indeed consciously treat) mobility itself.

La Rue says that we must learn to adapt ourselves to any surroundings. "But that is no reason why we should rest satisfied with all these things, or make no effort to improve our condition."—p. 280. Ambition is assumed all through the book. Self-confidence, a necessary entrepreneurial virtue, is extolled and Emerson is quoted as saying that "Self-trust is the secret of success."

Wells assumes that the aim of life is to get ahead, and that ambition is a prerequisite to a well-functioning mind. P. 11: "The free imagination of wished-for things results well for the mind through pointing in more glowing colors the excellence of what is wished for, and firing the ambition to strive for it the more intensely." The success vs. failure motif is apparent.

⁷ Morgan, p. 166: "Your birth means that you have been selected as a player in the greatest game ever devised. . . ."

Wells, p. 7: "Yet the worth of existence depends on success in a game infinitely more complicated than that of chess, in which no mistake is ever overlooked and no move ever taken back, and where knowledge from one's own experience often comes too late for use."

envy the other fellow his accomplishments or gloat over his failures, this morality is incorporated into the mental hygiene teaching—the prevention of mental illness becoming at the same time the prevention of delinquency and the encouragement of good sportsmanship.⁸ The healthy person is regarded as achieving victory against others only within the rules, by empirico-rational ingenuity and ascetic self-discipline. The maladjusted person must learn to face reality, i.e., the competitive facts.⁹ He must not achieve victories in fancy only, or flee the memory of his failures. Parents must not coddle their child and thus make him unfit for the competition of adult life. Yet since to face reality means not only to grasp the fact of competition, but also to estimate correctly one's chances, and since one's chances depend upon capacity and circumstance as well as effort, a safety valve for the competitive drive is provided by the advice that one should not aspire beyond one's ability.¹⁰

Because competition has for its goal a worldly prize, but a prize not to be won by self-indulgence, the implied existence of competition as a sane way of life is buttressed by the tacit preaching of *worldly asceticism*. Mental hygiene does not frown upon enjoyment for itself, but it does insist that recreation shall be "wholesome." In other words, one should not choose a type of recreation that makes one unfit for the serious business of life,¹¹ or which violates the canons of Protestant morality. One's behavior should manifest prudence, rationality, and foresight, and

⁸ Morgan, p. 38: "The fight of the mature adult is thus transformed from the childish attempt to resist all conditions which produce physical discomfort to the battle against any infraction against his self-imposed standards of behavior."

⁹ Shaffer states, p. 152, that one symptom of bad adjustment found in the inferiority complex is "a poor reaction to competition."

A literal translation of the phrase "personal efficiency," found so frequently in the literature, would be "competitive ability."

¹⁰ One of the five goals of "progressive" education, as listed by Zachry, p. 271, is: "The cultivation of ambitions which can be attained."

Morgan, p. 151: "Ambition must not be excessive." P. 22: "Facing life squarely is the first principle of mental health."

¹¹ Groves and Blanchard, p. 302: "The devotion of some leisure time to recreational pursuits is of positive value outside of the enjoyment which it affords, for it enables the individual to return reinvigorated to the more serious routine of study or work."

Another of the five goals of "progressive" education which Zachry lists is "healthful recreation."

material possessions should not be dissipated by whimsical extravagance.¹²

Individualism is tacitly assumed in three ways. (1) The person is held responsible for his own destiny. In case of neurosis his will is the object of treatment. In short he is the entrepreneur.¹³ (2) Individual happiness is the ultimate good. Mental health is interpreted as the satisfaction of individual needs.¹⁴ (3) Human behavior is assumed to be understandable in terms of individuals abstracted from their society. Needs, desires, and mental processes are frequently discussed as if inherent in the organism.¹⁵

Specialization is implicitly taken for granted in the emphasis upon the value of a particular kind of work adapted to one's talents and identified with one's own personality.

Utilitarianism is obviously assumed in the action philosophy of mental hygiene. To function, to grow, to do is regarded as the purpose of life. Tangible ends and Progress are regarded as the goals. Human welfare is seen as attainable by the application of rational science.¹⁶

¹² Wells, p. 276: "In life, the lubricating function of money to the social machinery is well known. It plays an equally essential part in the smooth operation of one's mental trends."

Shaffer, p. 539: The individual should "employ the scientific method for the solution of his personal problems." P. 382: It is assumed that rationality and insight are possible and desirable.

¹³ Shaffer, p. 539: "The chief requirements for hygienic work are freedom and success. Each person must be free to select the kind of task that is most suitable and most satisfying to him. He must have freedom to plan it and to carry it to completion in his own way."

Another of Zachry's five goals of "progressive" education is "personal independence—intellectual and emotional."

¹⁴ La Rue, pp. 11-12: "Happiness is, in general, the sign of mental health."

Stevenson and Smith, p. 1: "The child guidance clinic is an attempt to marshal the resources of the community in behalf of children who are in distress because of unsatisfied inner needs. . . ."

¹⁵ Shaffer assumes that individuals possess four types of motives which then come into conflict with the environment.—p. 86.

Zachry says that the child's "instinctive tendencies often conflict with one another. . . ."—p. 45.

¹⁶ Shaffer, p. 539: The individual should "employ the scientific method for the solution of his personal problems." P. 382: Assumes that rationality and insight are possible and desirable.

Another of Zachry's five goals is "purposeful and rational activity."

Morgan, p. 1: Life is ever-changing and demands continuous readjustment. It is "a game with a continual challenge which you must meet if you are to keep alive. Stagnation and death come when you cease to rise to the challenge."

If the thesis is true that mental hygiene unconsciously incorporates the open-class ethic, it should be further indicated by a study of the movement's personnel. Such a study, constituting a type of circumstantial evidence,¹⁷ was made, and it shows that the persons prominently connected with the movement are of the type one would expect to uphold the Protestant principles. They are mostly upper middle class professionals, predominantly of British ancestry, identified with a Protestant church, and frequently reared and educated in New England. Many of them apparently had well-to-do parents who themselves had risen in life through effort and initiative. Some of them are self-made men of undistinguished parentage in our own or in the old country. In general they seem to have taken to heart the necessity of a calling and have worked, abstained, and striven sufficiently to succeed. It follows from their background and is exemplified in their writings, that they believe in empirical science and have taken the American humanitarian religion seriously enough to apply scientific results zealously to the mental welfare of society. They are (without cavil) idealistic, respectable, and capable, and their sentiments lean on the side of humanitarian individualism.

Aside from the personnel of the movement, there exists for our main thesis still another (and more direct) evidence,—derived from examining a central and recurrent concept in the mental hygiene literature, namely, "mental health." This concept is usually defined as the "integration," the "balance," the "successful" or "happy functioning" of the personality;¹⁸ but these words

¹⁷ The survey includes data on the lives of 51 persons, leaders of the mental hygiene movement. With no funds for detailed historical or questionnaire research, we could not secure as many facts as we wished. Our conclusions are therefore tentative, but on the information we do have, taken from available bibliographical sources in obituaries, *Who's Who*, etc., they seem quite justified.

¹⁸ Howard and Patry, p. 24: "We have seen that the prime condition of mental health is the integration of the psychophysical and psychosocial organism through the development of stable major circuits of energy or good patterns of behavior." La Rue, p. 13: "Happiness is, in general, the sign of mental health. But it should be lasting happiness; for of course one can be happy for the moment, like the maniac or the drunkard, without having a mind that is really healthy." Richmond: the healthy personality is one which "functions more or less perfectly in its cultural milieu."—p. 148. Shaffer, p. 138: "For a person to satisfy all his motives with regard for their functioning as an interrelated system, is good adjustment. To achieve this requires unified and integrated behavior." Thom, p. 135: "The well-adjusted personality, which characterizes a happy and efficient man or woman, is a harmoni-

are as vague as the initial phrase. Furthermore, no adequate criteria for establishing the presence of this "integration" or "balance" are provided. The only consistent criterion, and in the last analysis the substance of every definition, is normal behavior. Consequently we shall examine what the mental hygiene literature means by the "normal."

Does "normal" refer to the statistical average of actual behavior, or to ideal behavior? It seems that mental hygienists have not seen the issue. In practice they employ the concept in both senses, though ultimately the normative sense prevails. There is in the literature much criticism of *selected* moral rules and attitudes. Sometimes the apparent basis of criticism is that the rules are unrealistic—i.e., that they are too far removed from the average actual behavior. Generally, however, the criticism springs (as it inevitably must) from value-judgments of the author. On the basis of his own conscious or unconscious values, the selected norm may be judged to be "irrational," "unenlightened," and detrimental to mental health. But whence come the author's values? Due to his position in society, and the nature of his work, they must come from the central valuational system of his culture.¹⁹ He can and he will criticize particular norms, but he cannot

blend of these varied emotions and character traits, resulting in self-control and habits of conformity." Wallin, p. 32: "That individual may be considered to be mentally sound and efficient who is able to react to his physical and social environment in an effective, consistent, and integrated manner. That is, an individual's mental soundness can be judged by the appropriateness and rationality of his behavior patterns on the psychological and social levels." Zachry, p. 263: "The integration of the self so that it acts in unity."

¹⁹ In the following passage quoted from Howard and Patry, pp. 146-148, we find an illustration of typical reasoning along this line:

"The moralists and theologians who were not able to give sex a rational explanation sought to stamp sex interest out of life. This only tended to dam up its force. [Condemnation of an old moral attitude on ground of its effects.] When psychoanalysis began to disclose it as a factor in mental conflicts, the so-called realists . . . began to play fast and loose with sex themes, with the result . . . a flood of sex liberalism. [Condemnation of current attitude.] . . . There is at present the need of a middle ground between the old attitude of avoidance and the present indiscriminate flaunting of sex themes. [Advocacy of a particular attitude.] Wholesome-minded people are not averse to frank consideration of sex under proper conditions and right motives, but they do not enjoy having it dragged into prominence on every possible pretext and occasion. Dignity and decency are the marks of successful sex adjustment. [Bolstering the proposed attitude with words and phrases of praise and redundant identification of it with health and the right

not impugn the basic institutions of his society, because it is in terms of these that conduct is ultimately judged to be satisfactory (i.e., adjusted) or unsatisfactory.²⁰

The ethical meaning of "normal" is further borne out by the fact that when specific advice is given concerning life problems, the conduct prescribed is ordinarily such as would conform to our ideals, not to the statistical average. The mental hygienist tends to justify such advice, however, not on moral but on rational or "scientific" grounds. One can best secure mental health, best satisfy one's needs, by conforming. But since for certain selected norms he does not advise conformity, the hygienist violates his own contention. Furthermore, he never brings the question of conformity or non-conformity to a clear issue, because he does not define "individual needs" or "adjustment" apart from moral norms, and because he does not admit that the delinquent may escape detection and hence punishment.²¹

If we are to understand the logic by which mental hygiene identifies mental health with normality, and normality with an unconsciously assumed open-class ethic, we must turn our attention to a central factor in this logic, to what may be called the psychologistic conception of human nature. By the psychologistic approach is meant the explanation of human conduct in terms of traits originating within the individual, as over against traits originating within society. Any explanation is psychologistic, for example, which builds its analysis upon motives, drives, instincts,

people.) In our approach to the problems and in procedures for the enlightenment of the young these qualities should be our guide and goal." [Assertion that everybody *should* accept the author's goal.] "In our attempts at sex education we have not yet learned to appeal to the highest motive—family formation. . . . Morality for its own sake no longer makes an appeal to young people. All moral codes should be tested by the degree to which they contribute vital values and call out deeper potentialities." [Justifying the proposed attitude on the basis of its connection with a fundamental institution and hence the central system of values in the culture.]

²⁰ Here we see an illustration of the conflict between the humanitarian mores (by which certain established practices are criticized) and the organizational mores (the more basic and unconsciously accepted standards). See W. Waller, "Social Problems and the Mores," *Amer. Soc. Rev.*, i (Dec. 1936): 922-933.

²¹ It is often difficult to get behind the emotionality and loquacity of mental hygiene literature to see the essential logic. This paragraph is meant to describe the general features of its main position after all the verbiage has been laboriously sifted.

urges, prepotent reflexes, or what not, ignoring the social genesis of what is called by these names. In mental hygiene these elements are taken as given in the individual, existing prior to social forces and determining concrete actions. Since they are prior to the social, the only other alternative in accounting for them is that they are biologically given. The psychologistic interpretation is individualistic, then, in the sense that it bases its explanation upon that which is purely individual, i.e., the biologically inherited constitution (the purely non-social part) of the person.

It is natural that mental hygienists have adopted this conception of human nature. Protestant individualism finds here a scientific rationalization. The philosophy of private initiative, personal responsibility, and individual achievement falls easily into an interpretation of human nature in individualistic terms. Furthermore, for those who are naive in the analysis of social relations and generally unaware of the sociological premises of their own thinking, it is extremely easy to read into the individual, as given in his nature, the characteristics that are really given in his society. By thus reading social traits into original nature a degree of permanence and certainty is given them which would disappear if they were realized to be merely socially acquired. In other words, psychologism is a means whereby an unconsciously held ethic may be advantageously propagated under the guise of "science." It protects the hygienist from a disconcerting fact—the relativity of moral judgments.

Yet, if applied with logical rigor to matters of conduct, the psychologistic approach would become an incompatible element in mental hygiene doctrine. Since mental hygiene constantly judges life-situations to be wholesome or hygienic according to whether or not they satisfy individual needs, the concept of "individual needs" calls for strict definition. If defined according to a logical application of the psychologistic approach, individual needs would reduce to those that are biologically inherited—namely, the organic. Applying this point of view to conduct, mental hygiene would urge us to satisfy our physiological needs independently of social standards and ideals, and to observe such standards and ideals only in so far as they can be proven to satisfy our needs. Of course, the hygienists do not do this. Instead they inculcate the dominant morality of a mobile society. They do not, then, apply the psychologistic approach with logical rigor, but misinterpret it by including as given in the individual many things which are in

reality not genetically but socially determined, such as desires and standards. These social desires and standards construed as inherent in the individual are precisely the Protestant standards that the mental hygienist implicitly follows. It is no wonder, then, that the "scientific" hygiene yields results in striking conformity to the ethical configuration, seeing that the ethical configuration is intrinsically contained in the very definition of the goal to be achieved—namely, satisfaction of individual needs.²²

We have shown thus far, by its preachments, its personnel, and its conception of mental health and normality, that mental hygiene tacitly assumes the Protestant open-class ethics. Let us now turn to the *results*, rather than the evidences, of the implicit assumptions. We shall argue that the ethical presuppositions, plus the psychologistic approach, necessarily vitiate the scientific validity of much mental hygiene work by limiting and biasing the study of mental disorder and consequently the working conceptions behind mental hygiene practice. Specifically, the presuppositions lead to neglect of the invidious element, and in fact social elements generally, as a determining factor in mental disorder.

An aspect of social relations possessing strong presumptive evidence of responsibility in mental disorders is precisely that which embraces invidious, discriminatory differences. If we suspect already that social forces are implicated, our suspicion becomes doubly certain for this particular branch of social phenomena. Sociological analysis of personality has long stressed the individual's conception of his role in the eyes of others. It has maintained that the self develops through the acquisition and

²² Mental hygiene turns out to be not so much a science for the prevention of mental disorder, as science for the prevention of moral delinquency. Thus an author may state that every individual has a need for some kind of useful work, then draw the conclusion that every individual *must* have useful work to be mentally adjusted, and finally declare that any social customs which do not permit this are irrational and unworthy. The conscious premise, that every individual has the alleged need, is a psychologistic fallacy. The other propositions, avowedly based on the initial premise, are in fact the product of countless un verbalized values which together represent an accepted ethical system.

We are thus able to account for the extraordinary diffuseness of mental hygiene goals. Mental health being defined in terms of conformity to a basic ethic, the pursuit of mental hygiene must be carried on along many fronts. Also, since the fiction of science is maintained, the ethical character of the movement can never be consciously and deliberately stated—hence the goals must be nebulous and obscurantist in character.

internalization of the attitudes of others. It has shown that these attitudes, laden with approval or disapproval, not only become in time the foundation of the self but also assume tremendous emotional importance for the individual.²³ Since the attitudes of others are acquired only by symbolic communication, which is social in the strictest sense and necessarily connected with the cultural heritage, it can be seen that the key to the relation between organism and culture lies precisely in the dynamics of the social role. And since the social role is largely a matter of the communicated approval or disapproval of others, involving a constant comparison of one's own position with that of others, the invidious, emulative element is inevitably present. In so far as personality and mentality are socially determined, they are also emulatively determined.

As a slight test of this theory, an analysis of 70 hospitalized cases, reported in the psychiatric literature and mostly with functional disorders, was made.²⁴ All but four instances showed clear evidence of status involvements. Furthermore, the evidence would seem to bear out Campbell's contention that in the functional disorders the emotional problems are of sufficient intensity and consistency as to indicate a causal relationship.²⁵

It follows that in the study of mental disorder, some attention should be devoted to the invidious elements in the social past of the patients. This holds true especially for the functional derangements—those, presumably, with which mental hygiene is most concerned.²⁶ But in mental hygiene at least, this phase of the subject has been neglected.²⁷ Much attention has perforce been de-

²³ The works of Cooley, Mead, Faris, and Dewey are here referred to.

²⁴ This study, though merely a straw in the wind, satisfied us that significant research could be carried on in this direction.

²⁵ C. M. Campbell, *Destiny and Disease in Mental Disorders*, N. Y., 1935.

²⁶ In so far as mental disorder results from definite disease processes, its prevention lies within the province of the ordinary public health program, the field of physical hygiene. Only when it is seen as somehow resulting from non-physical forces (Campbell's "personal" as opposed to impersonal factors) does it fall within the province of *mental* hygiene.

²⁷ Mental hygiene literature sadly neglects to analyze social processes, whether invidious or otherwise. Much is of course written about the importance of "environmental factors," but these so important "factors" are scarcely ever treated so as to discover their specific mode and intensity of operation.

The same criticism applies, though in lesser degree, to psychiatry and abnormal psychology. In them too, even when a school is dealing avowedly

voted to guilt feelings, inferiority complexes, anxiety states, and emotional conflicts. Yet though these clearly reflect the power of invidious comparison, they are hardly seen to be social at all. The

with superiority and inferiority, there is a tendency to regard these as individual traits and not explore their social origins. This is true, for example, of Adler's so-called individual school of psychology. The limitation of his point of view has caused him to miss essential features of the very phenomenon he insists is important. Again we may mention the works of Dr. Macfie Campbell, who very skilfully points out the causal importance of what he calls personal factors, but disclaims any attempt to analyze these factors systematically. What he calls "personal" could equally well be called socio-genic, and studied sociologically.

Mental hygiene's neglect of social process springs partly from the fact that mental hygienists are for the most part trained psychologically to look for bio-genetic determinants, rather than sociologically to look for social determinants. But it also arises from the sociologists' own failure to clarify the role of social interaction in the etiology of mental derangement. At any rate mental hygiene seems to be limping along on one foot, because if there *are* social determinants, these are not being discovered and utilized in prevention.

Detailed proof and knowledge of determining social processes will not come until case histories are invented and utilized which give the *significant social part* of the patient. Such histories wait upon two achievements: first, the development of a conceptual scheme which, as a first approximation, indicates what facts in the social past are significant, hence guides the research from the start; and second, the perfection and standardization, and the possible invention of new, techniques of social investigation. The first achievement has perhaps been realized in sociological theory, but its application in the gathering of social data about specific patients lags far behind.

While much of our sociological work has not been sufficiently detailed to apply to the etiology of mental disorder, it does point in directions where further investigation may prove fruitful. This is true, for example, of the ecological and comparative approach to the distribution of functional disorders. In other words, though we cannot give an exact description of the operation of social determinants in particular psychoses, we have strong evidence, if not proof, *that* such determinants are there. The *how* need not escape us always. In the last analysis it seems that sociologists could be expected to produce the required knowledge, because they, of all those interested in the problem, are the only ones devoting themselves purely to social relations as such.

Of the two great systems of causation with reference to personality—one the biological (cellular interaction) and the other sociological (communicative interaction)—neither can be ignored by any science of mental disorder. Thus far, however, it seems that far more energy, thought, and money have gone into the investigation of the first. Problems are even stated in such a way as to preclude investigation of the second, and concepts are used which are stopgaps rather than invitations to a knowledge of it. And yet there exist countless evidences that sociological factors play a significant part in both normal and abnormal behavior.

vertical element is merely assumed; it remains unanalyzed while attention is turned to "instincts," "reflexes," "habits," or other bio-individual determinants.

Now if we ask why this neglect, the answer seems obvious. It is a product of the implicit assumption of an open-class philosophy of life. Little attention is paid to the emulative, discriminatory social factors because to analyze them would bring to awareness the unconscious ethical premises. Such analysis would force recognition of the vertical dimension of our society and the axiological judgments associated with it, which have been assumed as premises. Hence it would destroy the myth of scientific objectivity and the myth of the universal individual—myths necessary to the self-confident optimism of the mental hygiene movement.

The logical device by which this blindness to invidious social determinants is made to appear satisfactory to the conscious minds of the mental hygienists, is the psychologistic approach. If human personality is understandable without reference to social reality, then naturally social reality need not be analyzed. The latter can be accepted superficially as something to which the personality must adjust, something which represses or facilitates original wishes; but the more fundamental social forces are not reckoned with. If they are treated at all it is erroneously—the social elements being regarded as inherently given in the individual (i.e., as non-social).

To show that mental hygiene has neglected genuine factors, and to indicate further why it has done so, it is worthwhile to reflect upon some possible connections between the class structure and mental disorder.

Be the causes of mental disorder what they may, it is easy to show that the criteria are always social. Sanity lies in the observance of the normative system of the group. This allows wide latitude, of course, and we constantly make allowances for a person's rearing in the specialized culture of his particular groups. But sanity assumes acculturation in some group, and basically it is acculturation in the central mores of the widest society in which the person is an effective social unit. Furthermore, we do not judge by one lapse. We judge, rather, by systematized behavior and ideas in a direction contrary to the accepted motivational complex. Thus a criminal is not regarded as insane because he does something contrary to mores and law. Stealing is an occurrence inherent in our social organization, and we all can see

the logic of motives for stealing. But a man who steals because of a motivational complex contrary to the accepted one—say, a kleptomaniac—is judged to be mentally disordered: not because he steals, but because his reasons for stealing are removed from “reality.” A man who forgets is not insane. We all forget. But a man who forgets the wrong things, such as his own name, his own city, or the excretory separation of the sexes, is definitely crazy.

In a class society the motivation of one class is understood by the members of other classes, because they each, in conforming to their class standards, are really conforming to the system of standards that constitutes the society. It may be that class ideologies, considered in themselves, vary in the degree of mental health they give their adherents; but this opinion assumes something that we do not possess—namely, a standard of reality by which all ideologies may be judged. In any culture the class ideologies are merely specialized parts of the central ideology, which is not identified simply with the outlook of the dominant class, but with that of all classes.²⁸ It is not necessarily true, therefore, that the more divergent the class ideology from the cultural standard, the greater the incidence of mental derangement in this class. It is a particular kind of divergence that counts, a divergence in the ultimate norms which unify the entire society and knit together its specialized groups.²⁹ In case of such divergence other classes will focus attention upon the errant one and will seek to control its thinking and behavior through methods conforming to the sanctions of the society. But the important point is that a specialized part is not necessarily divergent in this latter sense. The ideological peculiarities of a particular class may be adequately provided for and incorporated in the central ideology.

This conclusion seems valid in a caste as well as an open-class organization, and is partially valid even where class struggle ex-

²⁸ A class structure presupposes a hierarchy of values. Who possesses the highest values, or possesses these in the greatest degree, is of the highest class. It does not follow, as some would have us believe, that the system of values was instituted for the benefit of the upper class. Rather the system of values sets the framework and determines the goals of competition for position.

²⁹ This observation seems to be justified by the ecological studies of schizophrenia that have been made. Areas in which conduct violates the norms of the very society of which the persons are a part, are areas of high incidence. Cf. R. E. L. Faris, “Cultural Isolation and the Schizophrenic Personality,” *Amer. Jour. of Soc.*, xl (Sept. 1934): 155-164. Also, H. W. Dunham, “The Ecology of the Functional Psychoses in Chicago,” *Amer. Soc. Review*, ii (Aug. 1937): 467-479.

ists. So far as mental disorder is concerned, the significant question is not whether there is a caste or class system, for neither one is inherently destructive of sanity, but whether the system, whatever it is, is unified by a nucleus of common values. When the structure embraces conflicting principles of social organization based on incompatible values, psychic conflicts inevitably result. For example, ends may be presented to one group as possible and desirable, when in fact they are made impossible for that group by a conflicting mode of dominance. A clear illustration appears in the Southern part of the United States, where the avowed morality of equal opportunity to all is categorically denied in practice to Negroes.³⁰ The behavior of individuals caught in this situation manifests frequent attempts to escape an unbearable reality. Reality seems unbearable, however, only when another reality exists as a *conceivable* alternative; and another is conceivable only when it forms part of the social system and exists as a possibility within the cultural ideology. Mental conflict is engendered, then, not so much by the vertical structure itself as by inconsistency within the structure.

It might seem that a mobile class organization would have deleterious effects upon mental health because of the constant readjustments it requires of its circulating individuals. But the open-class system is protected against this adverse result by the fact that, as distinguished from a caste society, the limits of difference between the mores of different strata are narrow. If the differences were wide, vertical mobility, entailing a shift from one set of mores to a radically different set, would certainly have profound effects upon the person so shifting, and would end by prohibiting the change. But actually there is a tendency in an open-class system for differences in class modes of thinking to take the form of an infinite number of small gradations, and to reduce themselves to superficial externalities; so that though vertical mobility places the strain of rapid change, responsibility, and adaptation upon the individual,³¹ it compensates for this by the pulverization

³⁰ See W. L. Warner, "American Caste and Class," *Amer. Jour. of Soc.*, xlii (Sept. 1936): 234-237. J. Dollard, *Caste and Class in a Southern Town*, New Haven, 1937, especially pp. 72, 89, 182. Also K. Davis, "The American Caste System," unpublished manuscript in possession of the author.

³¹ Compare P. Sorokin, *Social Mobility*, New York, 1927, Ch. 21. Sorokin concludes that since in a mobile system the individual must adapt himself to changing milieus, mobility increases the incidence of mental disease. He admits increasing superficiality and externalization, however, but he interprets

and externalization of differences. The class variations in mores become one of degree rather than kind. The same fundamental wants and values pervade the whole hierarchy, the only difference being that members of the various classes satisfy these wants and attain these values in different amounts. The climber who moves from the bottom to the top finds that he can still utilize practically all of his old habituations. No fundamental reorganization is required. He merely satisfies the same old wants more readily and in greater abundance. Thus does the mobile society safeguard the sanity of the mobile person.³² Basically its members, of whatever class, all share a common set of values—the ethic of an open-class world.

In all this, however, it should be remembered that social class is but the roughest descriptive phrase for the invidious vertical aspect of society. Actually it is not class differences alone that count, but all differences describable in terms of inferiority and superiority. A person's class position offers but the first (though necessary) index of the social determinants in his life. It may be important or unimportant in his particular case, but in either event an indispensable consideration is the sequence of his invidious experiences within limited circles of association—particularly within primary groups. Yet it is precisely these relations, as well as general class factors, that (as already pointed out) have been neglected by mental hygiene.³³

Our speculations suggest that the vertical structure and mentality are intimately related, and that a neglect of social factors in terms of the individuals concerned and does not realize that they are even more characteristic of the cultural differences between classes and therefore constitute a compensation for the mental strain. It is only in the initial stages of becoming a mobile system that a class order may engender insanity. But this is a period of social change, and the increased incidence is due to our principle of conflicting values and not to the sheer fact of mobility itself.

³² The open-class society is also protected by the fact that the class sieves are never entirely open and hence most people move only a few rungs up or down. For this additional reason the changes required of any individual are usually not overwhelming. It should be remembered too that the open-class ethic places a positive value upon upward movement, and that even in the case of failure it always holds out hopes of recovery and progression. A person's mobility thus fulfils the values.

³³ Psychiatry is waking up to the necessity of studying interpersonal relations. See H. S. Sullivan, "A Note on the Implications of Psychiatry, the Study of Interpersonal Relations, for Investigations in the Social Sciences," *Amer. Jour. of Soc.*, xlii (May 1937): 848-861. Also Karen Horney, *The Neurotic Personality of Our Time*, New York, 1937; and the works of Macfie Campbell.

is a vital neglect for the mental hygienist. We have already said that there must be, and is, a reason for such neglect. It is obviously not our view that the mental hygienist is consciously enforcing alien class standards upon unwilling members of a lower stratum. Doubtless there is a tendency to spread the middle class Protestant ethic to classes which are not middle and hence not so mobile, but this could scarcely be interpreted as class "exploitation." We believe, rather, that the mental hygienist is really enforcing, in a secular way and under the guise of science, the standards of the entire society. This leads him beyond the goal of mental health, strictly defined, and to undertake such things as increasing the efficiency of the ordinary individual and readjusting some of our (more superficial) mores. Thus the diffuseness of the mental hygiene goal is integrally related to the hygienist's actual function. Mental hygiene can plunge into evaluation, into fields the social sciences would not touch, because it possesses an implicit ethical system which, since it is that of our society, enables it to pass value judgments, to get public support, and to enjoy an unalloyed optimism. Disguising its valuational system (by means of the psychologistic position) as rational advice based on science, it can conveniently praise and condemn under the aegis of the medico-authoritarian mantle.

Few will doubt that mental hygiene has thus far been less successful in achieving the avowed goal of prevention than has the regular public health movement. Does this represent a lag which will shortly be overcome, or does it represent a circumstance inherent in the nature of the case? The latter view seems more tenable, for the following reasons.

"Scientific knowledge of mental disorder requires knowledge of social determinants. But there is a social restriction upon the impersonal analysis of personal relations, and especially upon the use of knowledge thus gained. Such knowledge must be employed only for culturally prescribed ends and persons who believe in these ends. Unfortunately, if one serves and believes these cultural ends, one cannot analyze social relations objectively."³⁴ If

³⁴ Psychiatry, as shown by Campbell, Horney, Sullivan, and others, has gradually come to realize the importance of social and cultural factors in the determination of mental derangement. Generally, however, there has been an overestimation of the power this places in the hands of the practitioner. As reported by a sociologist who has spent some time as an observer in a mental hos-

this is true of an individual, it is even truer of a movement. The latter, dependent upon public enthusiasm, must inevitably adhere to ethical preconceptions. Mental hygiene hides its adherence behind a scientific façade, but the ethical premises reveal themselves on every hand, partly through a blindness to scientifically relevant facts. It cannot combine the prestige of science with the prestige of the mores, for science and the mores unavoidably conflict at some point, and the point where they most readily conflict is precisely where "mental" (i.e., social) phenomena are concerned. We can say, in other words, that devotion to the mores entails an emotional faith in illusion. Devotion to science, on the other hand, when social illusion constitutes the subject matter of that science, entails the sceptical attitude of an investigator rather than of the believer toward the illusion. In so far as the mental hygienist retains his ethical system, he misses a complete scientific analysis of his subject and hence fails to use the best technological means to his applied-science goal. But if he forswears his ethical beliefs, he is alienated from the movement and suffers the strictures of an outraged society. Actually the mental hygienist will continue to ignore the dilemma. He will continue to be unconscious of his basic preconceptions at the same time that he keeps on professing

pital, some doctors and psychiatrists assume that with further knowledge of social factors, these can be immediately changed so as to reduce the incidence of mental disorder. But for very profound reasons we cannot plan or alter our culture out of whole cloth. However, there is another type of optimism which is slightly more justified. This involves concentrating upon special or limited social environments as the field of social manipulation. Each of these has been studied in connection with the possible genesis of mental disease, and certain reforms advocated. But often, as in the case of the individual when he was first studied apart from his culture, the possibility of changing these particular social milieus is easily over-estimated. They are parts of our general culture, and resistances to changing them arise which were not at first apparent. Of course one particular individual's relation to one of his special social environments (say the court) can be helpfully altered, but this is casework and does not alter the situation so far as the general population is concerned. (For a detailed consideration of the problem of manipulating limited social milieus, see K. Davis, "The Application of Science to Personal Relations, A Critique of the Family Clinic Idea," *Amer. Sociological Review*, i (April 1936): 236-251.) Some features of society, moreover, are scarcely limited to any particular milieu. One of these is the class structure which, as a phase of the entire social organization, cuts across all special parts of that organization. When speaking of such factors it is difficult to advocate their immediate removal or change without becoming involved in ethical controversies and unseen consequences far transcending the immediate problem in hand.

objective knowledge. He will regard his lack of preventive success as an accident, a lag, and not as an intrinsic destiny. All because his social function is not that of a scientist but that of a practising moralist in a scientific, mobile world.

THIRTY-EIGHT

Social Values, the Mental Health Movement, and Mental Health*

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ANY ATTEMPT to describe the relations between social values and mental health must take account of the social movement that marches under the banner of "mental health" or "mental hygiene." That movement is itself an expression of, and a result of, a revolution in social values; it also affects social values, and, presumably, mental health. I should like, therefore, first to state briefly how the sociologist looks at the relation between social values and personality, and what he knows about it; second, to turn attention to the origin and growth of the mental health movement in relation to general changes in the values in our culture; and, last, to raise some questions about the effects of the movement both on values and on mental health.

I have written from two perspectives. *As a sociologist*, I have attempted to view the matter as dispassionately, not to say coldly, as possible—in effect, to view the movement as if I were a detached outsider. *As a citizen*, and moreover as a person in intimate touch with and sometimes involved in the movement, I have written also from the perspective of the "insider." I feel confident that the reader will easily disentangle what is said from one viewpoint from what is said from the other, and be able to make due allowance for the bias inseparable from each view.

"HUMAN NATURE IS SOCIAL NATURE"

It is the general viewpoint of the social scientist, his proper professional bias, that man is human in virtue of his *social* nature:

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"human nature is social nature." Unless the meaning of this statement is clearly understood, it may seem to claim either too much or too little: it may seem presumptuous and imperialistic, or trivial and tautological.

As to the first, the social scientist does not deny or ignore the fact that man exists as a physical object, that he can be dropped and smashed like a crystal goblet. Man does exist as a physical object, and if a physical force is sufficient, as the flight surgeons can tell us, his physical and human nature will be radically and sometimes irreversibly altered. Similarly, the social scientist does not deny or minimize the importance of the fact that man exists also as a biological object. The extraction of a few cubic centimeters of fluid or tissue will change the wonder of a biological going concern, an organism, into a mere aggregate of unstable chemicals; and, with that transformation, human nature will disappear.

What the social scientist is contending is that no matter what light may be shed on man's nature by *any* analysis (not merely present analyses) that is couched in the terms of physics or biology, these sciences furnish explanations only of *necessary* conditions for the behavior of human beings as human beings, and not explanations of *sufficient* conditions. There are physical, chemical, physiological, and anatomical conditions without which a man cannot exist or continue as a man; but no compilation of such statements of conditions will account for that in him which is distinctively human. We may account in physical-chemical-physiological terms for the fact that men grow periodically hungry, but this they share with the animals. But to account for the fact that they—or some of them—will go into a restaurant, read a menu, smile seductively at the waitress, have a moment of guilt or elation about that, and then proceed to order lobster newburg because it is a prestige-laden food (as against, say, shepherd's pie), we have to turn to an order of explanation that is not physical-chemical-physiological, for these are distinctively human acts.

To the charge of triviality (that the social scientist is saying what everybody already knows, namely that social behavior is a "part" or aspect of human behavior) the answer is that this is not what the social scientist means, either. He means that (given the necessary physical and biological conditions) *all* that is distinctively human about man must be wholly and solely accounted for

in terms of his social nature. He means that man is made human by humans, and in society. He means that it is in social life, and only in social life, that the welter of mere potentialities with which man is born is organized and given form and operability and access, via communication, to a share in the common human life and, via that, to a human life of his own.

This general view is buttressed by large-scale observations of the process in differing societies and by a limited amount of evidence as to what seems to happen to people who by some freak of fortune have become isolated from the humanizing (or socializing) process at some critical juncture. On the basis of this view, the social scientist is faced with the task of describing in some more useful detail just how the process proceeds—what are the relations between “culture” and personality, “social character” and social organization, personality organization and disorganization and their social correlates, if indeed they are correlated, as the general outlook would lead one to suppose.

WHAT WE DO NOT KNOW

We are here at a very unhappy stage in the development of our sciences—unhappy, that is, for those who feel, properly I think, that the questions are of overwhelming import and their answering of considerable urgency. I can hardly doubt that such feelings are justified at a time when attempts to rationalize social life founder on the intractabilities of personality organization and when attempts to improve the quality of personality organization come to grief on the brute rock of social organization.

It would be going much too far to say that we know very much about the relation of social values to personality organization and disorganization. We do *not* know what kinds of “cultural discontinuities” or “contradictions” are “dysfunctional” from either a social or a personality viewpoint. We do know that the distress of many who select themselves as patients is focused around such contradictions, but we can hardly say that the one is the cause of the other, or what contributory elements there must be in the situation before such social factors can appear as personality stresses.

We have much reason to think that personality breakdowns are relatively infrequent in groups whose morale is high; that “morale” is a name for the powerful feeling released in the indi-

vidual who feels himself a member of a strong and important group; and that such unity is frequently a product of (as well as a cause of) the sharing of social values felt to be important. (The stress, it should be noted, is on what is *felt* to be so, rather than on what a detached observer might regard as the facts.)

We are somewhat chastened by the knowledge that the group in question may be, to the outsider, imaginary (for example, a man and his guardian angel, his totem, his idol, or his deity), or that it may be a group immediately present but of no discernible enduring or explicit purpose.

WHITHER GOES THE PROCESS?

Thus far, we cannot even clearly distinguish between those forms of disorganization (personal or social) which are necessary phases of reorganization, improvement, and "growth" (and therefore "benign") and those phases which are the beginnings of continuing disorganization, disimprovement, and, finally, the disruption of the person or society.

It is easy, of course, to be wise after the event, but it is not then that knowledge is needed. Is Billy's stuttering at this stage a sign of coming reorganization of speech habits with markedly increased ease and fluency, or is it the beginning of a process that will hardly permit him to speak at all? Is the crime or delinquency of a Chicago slum in the 1920's to be viewed as a *necessary* part of a process in which slums will finally be torn down because they are socially too costly, and replaced by places humanly habitable? If so, it is about as "pathological" as the baby's cry that tells us he is hungry and needs to be fed. Or is the delinquency a sign, on the contrary, that life in large cities is inimical to personality organization and social organization alike, and therefore either itself pathology or the evidence of it?

Both views are tenable, and are held; and which of the two is chosen depends in large part on the time span that is taken into account, as well as on the author's spoken or unspoken guess as to where the whole process is taking us (or being taken by us). If we view the phenomena as part of a process of "revolution" with a probably improved state at the end, it is difficult to view them much differently from the process of formation of antibodies in the face of mild infection—"good" coming necessarily out of "evil." If, on the other hand, we view the phenomena as part of a

process of "the breakup of the Western world," they may well appear either as parts of or signs of the general lethal disease.

None of us, I think, knows the answer. The important point is that, except after the event, it is difficult to distinguish disorganization from reorganization. Even where the distinction can be made, it is often easy to distinguish in a particular case (for instance, this patient) but not in general; or in general but not in any particular case.

SOCIAL VALUES AND THE MENTAL HEALTH MOVEMENT

Despite this mountainous lack of knowledge, there has grown up in the Western world an increasingly powerful movement concerned with problems of "mental health." The growth of that movement is of extraordinary interest to the social scientist whether or not he is directly interested in mental health, and since it affects the layman deeply and is likely to affect him more, it should also be of extraordinary concern to him. Let us therefore examine the origin, the nature, and the effects of this movement.

ORIGIN

When the going and settled order of the Middle Ages was disturbed and broken up, perhaps chiefly through the introduction of money, there was radical change in an old social structure, the feudal order, inevitably involving changes in the economics, the politics, the ethics, and the theologies of all the Western world. Unavoidably, man's relation to things, man's relation to man, and man's relation to what he projected as the ideal had to alter.

How men did things to and with things altered; these alterations constituted the "revolutions in technology." *What* men knew about things altered, enlarged, and expanded, giving birth to natural science viewed as a body of knowledge. And *how* men knew about things changed; natural science as a method came to dominate over revelation and tradition, and the testimony of scientists came to have greater weight than the opinion of priests or ancestors.

In the relation of man to man, somewhat the same sequence followed. Men, related to one another primarily by force, authority, tradition, and love, were reorganized in relations that depended more nearly on force, advantage, calculation, cupidity, interest,

distrust, and fear. The market became the dominant institution, virtually replacing all such mystical bodies as family, church, and, later, guild. Similarly, what men knew about themselves and one another changed, giving birth to the social sciences viewed as a body of knowledge. And the ground upon which they accepted or rejected knowledge about themselves or one another changed to some degree also as the social sciences provided new methods of securing reliable knowledge about man. This revolution is by no means complete, and the traditional sources of knowledge still compete openly and forcefully in both popular and scholarly literature for the right to have their testimony accepted and its source accredited.

In the realm of value, or the ideal, the revolution is hardly well begun. Save for the obvious passing of the dominance of the one institution, the church, which formerly exerted almost undisputed sway in defining both what is and what ought to be the order of goods, nothing is clear. That no church any longer organizes the lives of men in so many respects or at so deep a level as the church once did, it would be difficult to doubt. But what has passed clearly—and, the author believes, finally—from the church has devolved exclusively upon no other body, nor has it even become dominantly concentrated in any. Who today has the right—for whom—to an authoritative pronouncement as to what is the good life, as to what is the order of the virtues, as to whether there is a supernatural order, and if so, what it is and whether it matters? Has scientist, priest, artist, philosopher, psychiatrist, or Man of Distinction this right?

ROOTS

Into this power vacuum the mental health movement has been drawn—together with a variety of competitors from neo-orthodoxies to new inventions, such as the omniscient State. With one foot in humanism and the other in science, it seeks to perform, and to a degree does perform, many if not most of the functions of the relinquishing institution—plus, perhaps, some others. A revolution in social values is what gives birth to the movement, and it is a revolutionary doctrine that the movement is moved by and expresses.

The power vacuum created by the bankruptcy of other institutions, however, furnished only the condition in which a new institution could "move in," and does not fully explain it.

There are three other roots of the mental health movement in the "great revolution."

First, such a time of radical and widespread change is likely to be (or to be *felt* as) a time of acute stress and deep distress. It will in and of itself (and it has done so) cause people to turn sustained attention and effort not only to the life without, but also to the nature and vicissitudes of the life within. And the latter is precisely the area of specialization and concern of the mental health movement.

Second, such a time will tend to call out (and it has) a spate of new social inventions—ways of dealing with human problems; and these, if they appear at a sufficiently rapid rate, will in turn call out mediators of the new ideas. And this is precisely where the mental health movement operates—between the scientific pen and the lay eye.

Third, whether or not there has been a net increase in misery of a psychological nature, the existence of a movement directed to its remedy or alleviation will tend to focus concern upon the problem; that is, in effect, to expand the market which it is equipped to supply.

This will tend to be more readily possible in a situation in which there is a diminution of suffering from natural disaster, famine, or the want of material objects. Lightning rods, ever-normal granaries, and the mass production of goods *permit* us to pay some increased attention to the inner life. The mental health movement *encourages* us to do so; the nature of present-day life virtually forces it upon us; and the disappearance of the formerly accepted and accredited ways of so doing inclines us to the trial and adoption of new methods. So we move from the "cure of souls" in either of its senses to "psychotherapy" and "mental hygiene"; from preoccupation with salvation to preoccupation with adjustment or peace of mind; from the attack upon evil to the war against anxiety; and from obedience in a service which was perfect freedom to a search for autonomy in a freedom without which no service can have dignity.

COMPARED WITH CHURCH

That the situation described presents some remarkable parallels with the situation confronting the early Christian Church should occasion no surprise. That the general shape and form of the resultant movement should in many vital particulars resemble those

of any other church ought also to occasion no great astonishment.

Like the early church, the mental health movement unites and addresses itself to "all sorts and conditions of men," so only they be "for" mental health as they were formerly for virtue and (more mildly) against sin. Like the church, it consists of a body of laymen and specialists, with the latter having as their special charge the psychological welfare of the former, to be worked out, however, by both together. Like the church, there is a "fellowship of all believers" that transcends great variety of belief, but differentiates from the unbelievers—both those who are against "all that" or simply not for it.

As in the church, a vast variety of activities are carried on whose principal unifying element is that they are all thought to lead in some degree to the furthering of the common end, though they are not all of equal importance; the monastic work of research, somewhat abstracted from the trials, tribulations, and rewards of this life, is frequently thought more important than the life of teaching and rescuing "in the world" with double risk of reward and seduction.

But much more important than these incidental analogies is the fact that the movement occupies or seeks to occupy the heartland of the old territory. The protagonists and practitioners of mental health are increasingly called upon to pronounce on what used to be called moral questions, in the small and in the large, in general and in particular.

The pronouncements cover matters of both substance and method. Breast feeding of infants, for instance, is currently "good," not under divine dispensation or because it is "natural," but because the mental hygienists say—probably quite rightly—it will help to produce a "good" child from the viewpoint of mental hygiene. The production of "good" children in another sense—what used to be called well-behaved children—by bad means such as fear or conditioning or seduction is held to be bad because it militates against integration, which is close to the mental hygienist's *sum-mum bonum*.

Divorce is good or bad, not in and of itself, but insofar as it increases or decreases the mental health of the parties thereto; or, in a rare, wider view, all the parties concerned, including nonparticipants.

To say these things is by no means to attack or make fun of the mental health movement—quite the contrary. What is being said,

in effect, is that of necessity it has the form and flavor of a church; organization, a message or mission, a set of central values, committed servants—lay and professional—activities, orthodoxies and heresies, celebrations and observances, excommunications at need, and the felt power in moral matter to bind and loose.

This is also not to say that there are no distinctions to be drawn between this movement and the movements it wholly or partly replaces. There are profound and important differences. How else and why else should it be on the wax as they wane?

In the first place, the values embodied in the movement are this-worldly and secular, as opposed to other-worldly and supernatural. In the second place, it is man-centered—sometimes perhaps too narrowly (taking account only of this patient, and taking the social context for granted), but often with a wide view and a full sweep. Third, it is to an unusual degree nondogmatic (unless the dictum that there is to be no dogma is itself held to be a dogma) despite what has been said above about orthodoxies and heresies. In close touch with the changing deliverances of science, it has itself to partake to a large degree of the tentative attitude, and in this respect it resembles more the mystic wing of the churches which for analogical reasons had to keep themselves largely unfettered and open to the "free sweep of the spirit." Fourth, its role is to facilitate an ongoing process, to remove obstacles to action and enjoyment, to free and liberate rather than enmesh and enchain.

The mental health movement has thus arisen out of a collapse of ancient social values, it has caught up, shaped, and embodied new ones, and has made of "mental health," however vaguely apprehended or defined, an important if not dominant social value, and seen to its incorporation to a degree in the beliefs and practices of other institutions.

THE MENTAL HEALTH MOVEMENT AND SOCIAL VALUES

In the process of its own growth, the movement has, as already intimated, had reciprocal effects on the general social value scheme. To a very large degree, as the mediator of the inquiring spirit of the social sciences, it has acted with the other "acids of modernity" as a solvent of hitherto stable beliefs. Where are yesteryear's open champions of obedience, of the innate superiority of men over women, of the quiet, well-mannered child (at any price), of belief

in "original sin" or the fundamental baseness of man (or virtue, for that matter), in the unitary character of intelligence, in corporal punishment, in proprietary rights in children and women? They are still with us, as the wheelbarrow is compresent with the airplane; but in much the same places.

The mental health movement has not unaided made these beliefs and a thousand others unfashionable, not to say disreputable, but it has helped. But it has done far more than render discreditable beliefs discredited. It has created or helped create something that is new in history, or as new in history as anything ever is. It has focused attention on the inner life—or perhaps more exactly, the inner life in relation to the outer. And while every church has sought to do that, the difference is that this movement is in somewhat more intimate contact with scientific methods of discovering what the inner life is.

This is a difference indeed—a difference that makes a difference. For good or ill, the movement is a mediator or interpreter of the scientific message, rather than an opponent of it giving ground gracelessly and step by step.

The movement has not only focused attention on the inner life and its quality, but it bids fair to make that the touchstone of all other goods. This also is not new. But again, what is new is the gradual development of methods of increased sureness and reliability for the discovery of what that inner life is really like. "Know thyself," said the Greeks; but they hardly suspected the structure, not to say the content, of that which man least knows and most needs to know—his "unconscious."

This concentration upon, and heightened consciousness of, the nature of mental life is now so widespread as to ensure an appreciative audience for New Yorker cartoons about psychiatrists, Hollywood films about alcoholism or amnesia, mothers-aid books about the emergent little superegos and their resurgent little ids.

POSITION AS TO ULTIMATE VALUES

On the whole, the mental health movement has been content with its role of facilitation of ongoing process, and has had very little to say about final ends, or ultimate values. There are, of course, striking exceptions, as when a leader in the field says that Santa Claus (and his equivalents) must go, and as a consequence finds leagued against him a powerful combination of the sophisticated who have much to lose and the unsophisticated who have

nothing to lose but their strains. But the two persistent positions taken by the majority in the field have interesting consequences.

The first of the two positions states or takes for granted that mental hygienists are not concerned with ultimate values as such: they function at the *means* level, and their aid should be equally welcome under almost any scheme of ultimate values. The church, industry, the Nazi party, the socialist society all have mental health problems, and the mental hygienist can help all equally. Some have reservations, but the position is essentially that within a wide range of moral schemes, or in all of them, mental hygienists can aid and operate.

This is not quite moral indifference, though to many it will seem so. It is the precise analogue of the position of at least one church that it is above and beyond politics, and that—provided certain of its criteria are met—it can live in any form of polity and reach a concordat with any bargain-keeping government.

The alternate position consists largely in the attitude that ultimate values are matters for continuing discovery, and that therefore the business of the mental hygienist is to facilitate and further the endless common search. In this view, no values are ultimate; all are tentative and temporary, *except the values implicit in and necessary to the method of discovery itself*. This view puts a high premium on curiosity, honesty, intelligence, care, and boldness; and also, by implication, on due humility and proper responsibility in the human enterprise.

EFFECT ON SOCIAL VALUES

It may be felt that there is a great and unbridgeable gulf between these views; the present author feels that there is, and that this represents the latent first great schism within the movement. But in at least one important respect, the effect of each view upon social values has been, unwittingly, much the same.

That joint effect has been to shake confidence in any existent scheme of ultimate values, to lead people quite generally to conclude that such questions are unanswerable and that the answers are matters of indifference. No mental hygienist known to the author actually holds such views; many people known to the author draw such inferences from what mental hygienists say.

Selection between the two positions is as difficult as it is important, for the second is quite capable of making the search for ultimate values central to the human enterprise, which is where, in the

judgment of the writer, it properly belongs. But the first position has behind it the authoritative weight of the medical and priestly tradition that the profession is there to serve all comers, regardless of the use to which they intend to put regained health or grace. The alternative is very uncomfortable ethically and politically. Ethically it raises the problem of forgiveness: to whom, under what circumstances, may the means of health or grace be refused? Politically it means the return of the power to bind or loose to a body of professionals, with all the risks of corruption of one side and spoliation of the other that such power situations always have implied.

No matter which course is chosen, the effects on social values are already profound, and are likely to be increasingly so as money and power and prestige accrue to the movement, as they may well do at steadily increasing rates.

THE MENTAL HEALTH MOVEMENT AND MENTAL HEALTH

It remains to say a word, stemming largely out of what has been said, about the effects of the movement on that which it intended most to affect, namely, mental health. In the case of particular patient and particular therapist, it is difficult to doubt the high frequency of efficacious work. But it is rather with the general effect of the movement that we must be concerned.

Here, as elsewhere, we are largely in the dark; and yet a more important field for research could hardly be marked out. It is nearly always the unintended consequences of social policy, rather than the intended ones, that raise profound and harassing practical problems, and it would be strange if this were not so in the case of the mental health movement.

In areas where its effects have been concentrated, such as one of the communities presently under study by my colleagues and myself, these effects are very striking. They are so striking, indeed, that some of us have the feeling of being confronted with a social invention, whose disturbing size and power may well be at least equal to those of the industrial revolution itself.

What seems to be emerging is a situation in which laymen—ordinary men and women—in their everyday activities are coming into possession of and using a new body of knowledge and techniques of analysis with reference to themselves and to one another. The im-

portance of this may not be immediately evident, but the effect is almost as though another dimension (and another complication) had been added to life.

PAINS OF SELF-CONSCIOUSNESS

Self-consciousness in the ordinary sense, when it emerged in the process of evolution, meant inescapably the loss of that pristine innocence and naïveté which is the exclusive prerogative of non-self-conscious animals—an innocence and naïveté to which we all occasionally have deep-seated and understandable yearnings to return. It is very largely the burdens and pains of that loss that it is the business of mental hygiene to deal with. Self-consciousness, man's distinguishing gift, is also his primal wound. Undue self-consciousness is fatal to spontaneity, and heightened self-consciousness is a burden not lightly to be borne.

But as mental hygienists, we have now added to ordinary self-consciousness a self-consciousness of a different kind: different in its accuracy; different in its penetration and depth; different in that it continuously tears away the veil of privacy from what was hitherto private; different in that we are ourselves self-consciously engaged in building it up; and different in that we know that our immediate associates and friends are so doing, and that they know we know. This is in some important sense a radically new way of life.

What this does to the mental health of people going through the process is difficult to assess. That they are obviously relieved of some tensions and difficulties seems clear; that they are new-burdened with others seems evident also. That this is an additional stress for the neurotic and the near-neurotic seems likely. That it furnishes a new channel for old anxieties, and perhaps a particularly difficult and dangerous one, is hard to doubt.

But none of these would recommend against the process, even if the worst were assumed in each case. We cannot at all clearly distinguish between the pains of transition and the pains inherent in the new state of affairs itself. Much of what we see, we can be sure, is ascribable to the fact of change and not to the new state that may follow. We would be as wise to condemn the surgical knife because it hurts as to concentrate exclusively on the pains of change. The key question for policy is whether or not the new state is better (from a mental health viewpoint) than the old; and to that question we have no answer better than faith or guess.

NO RETREAT

But it is no longer even a question for policy. No known man or body of men now has the power to arrest the flow or alter the general direction of events, even if, on mental health grounds, that should be indicated. If we, the mental hygienists, should amputate our writing arms and seal our reluctant lips, the field would fall to the quack and the charlatan, and the principal difference would be that the self-consciousness would be worse-founded and more misleading. There is no choice open in that direction for us, any more than there is a way of abdication for the physicists in the face of the atomic bomb and its more violent variants.

What is really needed is that we should lay upon ourselves the same self-consciousness (and the responsibility that it carries with it) that we have laid upon others. We can no longer afford to shoot psychological arrows in the air and be satisfied that "they fell to earth I know not where." We need close and continuing research contact with the proximate and remote consequences of what we have said, so that, while we cannot control the wide sweep of events, we may make adaptations in particulars and cause the effects to be no more painful than they must be. To act otherwise is to act irresponsibly and to invite, if not to guarantee, disaster. The disaster would be that the very means of man's liberation, self-knowledge, would have become the instrument of his enslavement and the procurer of his impotence. This is not what we set out to do.

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